PUBLIC HEALTH: EVERYONE’S BUSINESS?
Welcome to the second publication in our series Provider voices, in which we promote the views of a select group of leaders on some of the key issues facing the NHS today.

We hope this will make a valuable contribution to discussions on how the health service can respond to the challenges ahead.

Our topic this time is Public health: everyone’s business? which, in our view, has never been more important nor more challenging. The Five-year forward view committed the health service to a “radical upgrade” in prevention and public health. There are many barriers. Progress can be patchy. But there is a strong evidence base for what works, and new approaches and partnerships are taking root.

There are a range of important issues to discuss: promoting the public health role as we move towards accountable care, dealing with the challenges of constrained funding, harnessing digital technology, developing the role of the public health clinician and working to shape the wider determinants of health inequalities.

It’s great to have 12 different sets of answers to these questions from a range of perspectives. We are grateful to the leaders who took the time to contribute to this publication. And we are grateful to Andy Cowper for carrying out the interviews.

Chris Hopson
Chief Executive, NHS Providers
WAYNE BARTLETT-SYREE
Director of Strategy and Sustainability
EAST OF ENGLAND AMBULANCE SERVICE NHS TRUST

DAVID BUCK
Senior Fellow, Public Health and Health Inequalities
THE KING’S FUND

DR MAUREEN DALZIEL
Chair
BARKING, HAVERING AND REDBRIDGE UNIVERSITY HOSPITALS NHS TRUST

DR JEANELLE DE GRUCHY
Vice-President
THE ASSOCIATION OF DIRECTORS OF PUBLIC HEALTH

GRAHAM JACKSON
Co-Chair
NHS CLINICAL COMMISSIONERS

PROFESSOR SIR MICHAEL MARMOT
Professor of Epidemiology and Public Health
UNIVERSITY COLLEGE LONDON

DAME GILL MORGAN
Chair
NHS PROVIDERS

PROFESSOR CHRIS PACKHAM
Associate Medical Director
NOTTINGHAMSHIRE HEALTHCARE NHS FOUNDATION TRUST

DR ARIF RAJPURA
Director of Public Health
BLACKPOOL COUNCIL

DUNCAN SELBIE
Chief Executive
PUBLIC HEALTH ENGLAND

SIR DAVID SLOMAN
Chief Executive
ROYAL FREE LONDON NHS FOUNDATION TRUST

PROFESSOR HEATHER TIERNEY-MOORE
Chief Executive
LANCASHIRE CARE NHS FOUNDATION TRUST
To quote Professor Sir Michael Marmot in his interview for us: “Public health is everyone’s business”. Rightly so. By its nature, public health matters to us all, whether we believe this to be the case or not. It is this characteristic that can make public health one of the most difficult aspects of our health and care system to define and delineate. Yet it also makes public health one of the most important elements of our system. It has the potential to deliver huge benefit in terms of individual and collective health and wellbeing. And, in this sense, it is the most inherently democratic: it is more able than other parts of the system to make use of formal and informal social and political structures.

This report uses 12 interviews with NHS trust leaders, from the hospital, mental health and ambulance sectors, as well as academics, system leaders, local government representatives, and those with strategic responsibility for delivery and commissioning, to help gain a better understanding of NHS providers’ role in shaping and delivering public health and care. What their words show is that there is a proliferation of ideas and perspectives. Some interviewees are population health advocates, others see the structured focus on the individual as key, while some promote prevention every step of the way. What links these interviews, however, is a shared understanding that a focus on public health has never been more important, nor more challenging.

Health inequalities

The thread that runs through any consideration of public health is health inequalities, and more specifically the wider determinants of health and wellbeing. A precondition to good public health is socio-economic prosperity and equity: individuals and communities being enabled to access the support they need to thrive. It is appropriate that public health’s national leader, Duncan Selbie, chief executive of Public Health England (PHE), talks so passionately about this:

“...A job, a safe and warm home and someone to care for and about are the foundation of what works for improving health and closing the gap between those who are affluent and those who are not...”

Professor Sir Michael Marmot goes to the heart of what we need to deliver equity:

“Really, it’s a question of social action. Individual behaviours matter enormously, but they are influenced by and conditioned by environments and social determinants.”

Finally, it is interesting that Wayne Bartlett-Syree’s broad view of public health – as East of England Ambulance Service’s strategy director – is informed by an updated version of the Beveridge’s five giants. “Squalor, ignorance, want, idleness and disease. Those five are still valid today, although the language changes...”
Squalor related to slums – now our issues are about social isolation and the gaps between rich and poor. Ignorance speaks to the power of education as a social leveller. Want has been turned on its head; the challenge now is consumption. Idleness is now inactivity “getting people moving has massive benefits”. And then disease; although the big public health killers such as cholera or diphtheria may have gone the context now is ‘multimorbidity’ rather than the single disease.

Perhaps none of these perspectives are brand new, but the context in which we are now operating makes the need to act even more pressing.

Navigating the system

No institution or individual can deliver public health alone. That is its strength. However therein lies an inherent weakness. Who leads? Who sets the strategic direction? Who is accountable and responsible for such a wide ranging set of roles, functions and initiatives?

With the UK in the midst of Brexit negotiations it might seem strange to turn to an EU concept for the answer to these questions. However one of the underlying themes to emerge is that public health is everybody’s business in different ways. A form of subsidiarity – operating at the appropriate level, closest to the people – is a key concept here. National bodies, councils, trusts, the third sector all have a different relationship to the individual. They operate at different levels and in different ways. It’s about identifying the most appropriate level for the most appropriate action. Alongside this, without genuine integration of services and functions, effective, value for money public health will be impossible to deliver.

It is critical that we remain true to the core intention to improve public health. One way of doing this is to think about how the structure of health and care delivery relates to the individual and wider communities and how this structure then impacts on them.

At a system level it is funding, strategic direction and national level actions that predominate. How much will we allocate to public health expenditure in aggregate, what is our strategic priority – prevention or promotion, and will national approaches make a difference?

Developing a sense of place is also critical and is likely to be a key determinant for successful public health. Getting the right unit of planning and defining the right community/communities is key here. This is where sustainability and transformation partnerships (STPs) and the move to accountable care are important. And where we also see the importance of geographical boundaries and operating at an appropriate scale.
Individual institutions – NHS trusts, councils or voluntary sector organisations – have a key role in delivering public health strategies. Each type of organisation has different accountabilities but they share the same need to align what they do with national public health priorities and have the right impact on the individual members of the public with whom they interact.

This latter point is key: the individuals that constitute the public of public health must be afforded proper agency. Any approaches where people are ‘done to’, sanctioned or punished will not work. In the words of Dame Gill Morgan: “We need to think about how to help young people use technology for health gain in exciting non-deadening ways. Too much public health messaging is boring, punish-y, “don’t eat this or that”. We need a school of social marketeers on how to encourage and nudge people effectively towards healthier decisions...”

Recent structural changes

Back in 2012 the much debated Health and Social Care Act introduced a new system for public health in England. At the heart of these reforms was the creation of the national organisation, PHE, and the transfer of public health functions from the NHS to local authorities. Every top tier authority (unitary or county council) appointed a statutory director of public health. This took place in April 2013.

Now PHE and councils both have a legal duty to reduce health inequalities in the commissioning and delivery of their services. PHE’s role is to provide national leadership as well as delivering appropriate services to protect and promote the public’s health. It also funds public health activity by commissioning services or allocating funds to councils.

Councils’ role is to improve the health of their population. A simple statement with a whole host of complexity underneath. Statutory health and wellbeing boards (which sit within councils) bring together health and social care commissioners, elected representatives and HealthWatch to integrate health and care to improve health and wellbeing. Their primary task is to produce a joint strategic needs assessment which sets out the needs of the local community. This should then translate into local commissioning priorities.

This structure has been in operation for four years. Overall it has delivered some significant benefits, with widespread support for councils leading the delivery of improved health outcomes for local populations, given their closeness to their local communities. A Commons health committee report1 indicates that the shift of public health to local government has been “largely positive”, integrating public health across policies and

---

actions that relate to the wider determinants of good or poor public health.

However some challenges remain. The structure is relatively complex, and these changes were introduced at a time of huge system upheaval with the implementation of all the proposals in the Health and Social Care Act. At the same time, local government has been through an unprecedented period of financial austerity with all local government budgets, including public health, heavily squeezed. PHE has also seen in-year and ongoing financial constraints.

A focus on the NHS trust role

Although the views expressed in the interviews are diverse, a number of issues relating directly to the NHS trust role in public health emerge:

- the impact of STPs and accountable care approaches
- funding challenges
- innovation and the need to embrace digital technology
- population health and the role of the public health clinician
- enduring importance of a condition specific approach.

The next section sets out more detail on these five areas.

Impact of STPs and accountable care approaches

For the NHS and local government STPs and accountable care are the new kids on the block. But the foundations on which they build have been around for a good while: the integration of health, care and other public services and the importance of a sense of place.

They have an important role in improving population health and reducing health inequalities as a key mechanism through which all parts of the health and care system can come together and agree shared plans, approaches and solutions. Many STP plans have been rooted in the notion that improving population health will reduce demand on the NHS, although that should not be its sole aim. This is reflected in the views of our interviewees, although not without challenge:

“We are starting to see a change of emphasis with the work of the sustainability and transformation partnerships which is refocusing our attention on system-wide solutions and on population health – helping people to achieve their maximum potential – rather than treating people when they get sick.” David Sloman

“In my view, STPs offer us an excellent opportunity to transform the ways in which health and care go about trying to improve the health of their patients and populations, and they are a smart way of looking at the health and care economy’s broader impact.” Professor Michael Marmot
“So, at STP and local delivery plan levels, we have a very strong focus on public and population health... This is driving us as leaders to think differently about people’s overall health and wellbeing... Can this be enough to help us mitigate the full impact of the financial challenges for public health? I’m not convinced.”

Professor Heather Tierney-Moore

Within STPs and accountable care, service integration and the need for connection and joining up is a persistent theme – both from the organisation’s perspective and the individual’s:

“As commissioners, we now look more widely to other partners to support the prevention agenda, but with public health sat in local authorities, there’s a worrying disconnect between the two. As we move into the world of accountable care systems (ACSSs) or accountable care organisations (ACOs) those kinds of disconnects are no longer viable or acceptable.”

Graham Jackson

“So from this co-located joint working, we can pull in colleagues from primary care, social services and acute care. This started as joint work with the district council, and it really changes the conversation and makes us all as providers and commissioners think differently about how best to support people.”

Professor Heather Tierney-Moore

“My vision is that by 2020, we will have an offer for people where we’ve done the integration for them, and it’s not left for individual service users to do, as it often is now. We’ll have a workforce who are skilled in interventions, without hand-offs between organisations, and a seamless place-based public sector offer...”

Dr Arif Rajpura

There has been much discussion around the geographical footprints for STPs. The need for that all important sense of place has come through strongly and also the need to operate at scale. Public health good practice can be plentiful at a micro-level, but we need to scale them up to macro-level actions:

“The Royal Free London is one of four trusts across the NHS chosen to develop a group model... Our vision is of a group of hospitals which have the scale and partnerships to be commissioned to improve population health outcomes. If we can organise ourselves at a population-based scale then we stand a better chance of solving our population health paradox.”

David Sloman

“The effectiveness of STPs varies predictably, with issues such as geography and local relationships playing a part in this. As a clinician, I want a local population focus to understand and meet that local healthcare need, which implies a smaller geographical footprint. But a small footprint can make it too hard to commission properly or reshape provision meaningfully.”

Graham Jackson

Without genuine integration of services and functions, effective, value for money public health will be impossible to deliver.
Funding challenges
Barely a day goes by without NHS funding making the headlines in one way or another. Cuts to health and council funding and their impact certainly predominate in these interviews:

“The financial challenges have too often led to a focus on short-term finances, and prevention efforts don’t always fit into short-term timescales... When you need cashable savings, it is that much more difficult to prioritise prevention efforts. It isn’t easy, but taking a medium to long-term approach is really critical if we agree to tackle the major health issues our nation is facing at the moment.” Jeanelle de Gruchy

“Reductions in local authority spending impact on the types of services people need from the NHS and services have become disconnected. Many of the demands of the most chaotic mental health service users are linked to drug and alcohol use/abuse and it is the early support services that have been damaged.” Dame Gill Morgan

“The money has dried up in local government, less so in the NHS although it’s more opaque as there’s less transparency on the detail of the NHS’ public health and prevention funding and spending...” David Buck

But it’s not just about cuts. It is also about the need to reform how we pay for the different inputs that make up the public health offer and put in place incentives to devise different approaches and types of activity. Graham Jackson’s commissioner perspective is insightful:

“This will mean changing payment methods: not removing the purchaser-provider split, but weighting more incentive away from payment-by-results style activity to help providers work with the rest of the sector to defer or reduce the activity we have to deliver down the line...we’ve run the health system in 12-month fiscal cycles for decades – it’s no way to deliver population health. It makes no sense to run a £110bn-a-year business in 12-month cycles, so we need the bravery to talk about how we’ll invest for the future to get a public health return.” Graham Jackson

Innovation and the need to embrace digital technology
Innovation is often born of a crisis. There has been much change, and even turmoil, in terms of changes to both the architecture of public health delivery and also the levels of funding. Against this backdrop many councils in particular have been innovative in finding different, and often more efficient, ways of making inroads into health and wellbeing, as demonstrated by the LGA’s report into public health transformation.2

Many STP plans have been rooted in the notion that improving population health will reduce demand on the NHS, although that should not be its sole aim.

---

2 Local Government Association, Public health transformation four years on, February 2017.
“...the other thing that those financial issues have done is to drive innovation. I’m seeing more and more people recognising the benefits of the third sector and what they can bring, thinking about strength-based and asset-based approaches. This has always been one school of thought in public health, but we in the more traditional statutory sector now need new ideas on how to support people to support themselves.” Professor Heather Tierney-Moore

“However, the cash crunch enabled local government to really look at ways to transform what it does: in that sense, it created opportunities to look to innovate and do things differently, and gave a chance to step back and explore how to improve population health through all elements of councils’ work...” Jeanelle de Gruchy

Digital technologies are an important means of delivering innovation, not only by diversifying how we engage with populations and the efficiency of interventions but also increasing the effectiveness of the data held. The interviewees with a provider background were particularly keen to emphasise this:

“The big enabler for positive changes to public health will be digital technology. We know that the expectations of our patients are higher than ever and in the digital age they want convenience, and expect data that’s bang up to date... We need more data and less intervention. Around 80% of healthcare data is currently unstructured, and digital technology can help us knit this together.” David Sloman

Population health and the role of the public health clinician

Over time the role of both the public health clinician in secondary care and the impact of population health more generally in strategic and service-level decisions has declined. Although this became more pronounced with the transfer of the statutory public health responsibility into local government four years ago, this was the speeding up of a pre-existing trend.

Public and population health approaches now lack their previous level of influence or popularity in NHS trusts. A lack of public health consultants can leave specific expertise gaps, including the data analysis to support healthcare decision-making. This is a loss to strategic capacity.

“We tried, but failed, to recruit a director of public health to advise our board, our executive and our staff... Without this expertise, our board decision-making and staff and patient behaviours lack a much-needed public health ethos.” Maureen Dalziel

“So public health specialists often get no opportunity to comment on prevention and value for money, especially in the work done within big provider units. To fix this, we need to see a consistently stronger population healthcare approach for trusts supported by public health specialists familiar with often quite complex healthcare...” Chris Packham
Alongside this, focusing more effectively on prevention in the secondary care sector is probably the area with the biggest potential short-term impact. By *Making every contact count* and changing the approach of clinicians to prevention some trusts are now playing an important role in population health management.

“One very practical thing we developed was a training programme for all staff in Making every contact count... Well over 50% of our staff are now trained in supporting patients in the areas of diet, activity, smoking, adverse childhood experience and behaviour change.”

Professor Heather Tierney-Moore

**Enduring importance of a condition specific approach**

So far this narrative has focused on populations, communities, places, services and approaches. However the importance of focusing public health work on prevention – both primary and secondary – of specific activities, conditions or behaviours endures. And rightly so. The biggest health gaps stem from the prevalence of smoking, obesity, drug and alcohol abuse, mental health conditions and the frailty of our older population:

“For us as an ambulance trust, our two biggest demand areas are mental health and falls; that makes up over 25% of our activity – mental health about 10% and falls 15-20%, most of which are in the frail elderly population... In mental health, it could be seeing patients through things like the blue light partnership, and using a street triage car to address those who come in to any of the 999 services... If we took a non-traditional service approach to this, it would be a question of how, as a provider, we could get into helping frail older people not to fall through home welfare checks.” Wayne Bartlett-Syrie

The final words in this section go to Duncan Selbie who exhorts the NHS to go completely smoke-free.

“Smoking accounts for half of the health gap between the poorest and most affluent and helping people to quit remains the number one opportunity to address this. Today in the NHS, 1 in 4 inpatients is a smoker and fewer than 1 in 13 of these has had a conversation with a doctor or nurse or any healthcare worker about why this might not be a good idea. There are more than half a million tobacco related admissions every year and for every smoker who dies early, 1 in 2, another 20 suffer tobacco-related diseases.”
Where next?
Public health is everybody’s business, it operates at every level and matters to national government as much as individuals.

The wide-ranging interviews in this report, reflecting the views of commissioners, providers, those operating nationally, regionally and locally, do provide some pointers about where we should be headed next:

- structurally – maintain and enhance the focus on the public health role of STPs and accountable care
- financially – reverse the cuts to local government public health budgets and shift payment systems so that the incentive is to prevent rather than cure
- clinically – reinstate a strong and strategic role for public and population health clinicians in provider organisations which will benefit all other parts of the public health system
- culturally – bring about a change in mindset across the NHS that is focused on public health and its role in empowering individuals to look after their health
- as the public sector – continue on the journey of influencing fundamental determinants of health and health inequalities.

Let’s give Dame Gill Morgan the final words here: “So let’s get back to a proper debate. Health services are not bad; primary prevention is not a panacea for the challenges of the NHS. A proper population and value-driven approach is needed now more than ever.”

Saffron Cordery
Director of Policy and Strategy, NHS Providers

with thanks to
Georgia Butterworth, Policy Officer, for additional research
THE INTERVIEWS

Thanks to Andy Cowper who carried out the interviews in this report
Wayne Bartlett-Syree
Director of Strategy and Sustainability
EAST OF ENGLAND AMBULANCE SERVICE NHS TRUST

Following the changes in the 2012 Act, I doubt that public health now sits in the place where it should be, structurally and philosophically. Nobody in the health world will ever argue that prevention is bad; they’ll all say it’s very good. But in the great Andrew Lansley reforms, it was moved away from the NHS, and then once it was transplanted into local government, it was no longer protected within the NHS budget ring-fence.

So are we saying that public health is essential to how the NHS works? It’s certainly the rhetorical king in the Five-year forward view, yet our former NHS colleagues advising and delivering on the theme have been moved completely away from the commissioners of health care!

Preventive mindsets not integrated

So does this change mean we now have system integration mindsets on prevention? The simple answer is no. We’re saying one thing and doing the polar opposite in statute.

My NHS career took me from sluice rooms to boardrooms, and I now work in strategy within a provider. Previous roles, working with public health on commissioning was always a great benefit to our understanding of population health, and from that, what interventions need to be put in place to keep the population well. Moving all that knowledge of how to deliver population health away from the NHS has had a negative effect on managing demand upstream.

Upstream

Where I work, we are keen to avoid patients having a mental health crisis that ends up with them deteriorating in police cells. Therefore, as a provider we have chosen to get deeper into working with our communities, precisely so that these patients get the right care and avoid a crisis.

This is the kind of way in which public health has to be forward-looking in working with the provider sector, helping identify evidence-based interventions. Our focus has to be about how to tackle these escalations or deteriorations early on, to reduce demand and help the system avoid draconian demand management through rationing policies or simple lack of service accessibility.

I’ve dealt with public health more recently in specialised commissioning, and they are great at telling us about the evidence and what rare disease treatments are available, but less good on the issue of how do we prevent some of this, and how we should look to reduce demand by getting it right upstream.
I’m now sat in a provider organisation, and I don’t see public health involved in our organisation nor in the secondary prevention agenda in the way it should be.

The five giants, updated

To involve public health more in healthcare planning, I have a little postcard on my desk with Beveridge’s five giants: squalor, ignorance, want, idleness and disease. Those five are still valid today, although the language changes.

Squalor was about habitation, and we have not got the slums of the past, but there’s a real divergence between the rich and poor, and now I think a big public health problem is in our lack of community leading to isolation of some of our most vulnerable groups. We know that older people get frail and isolated and this has negative consequences on their health and how they access healthcare. So that’s where we need to get the community and the wider public involved.

As for ignorance, education has been the great social leveller of the last century. The biggest difference between doing well or not in life, health and finance is the education gap. So what is public health doing about this?

Want has flipped to consumption – and our problem with consumption today is the polar opposite of the past. Today we see a rise of scurvy through people not eating the right things but not the lack of the right things. Of course there’s the massive rise in obesity. Twenty years ago, people thought that a high-salt diet caused cardiovascular disease; today, we’ve got huge problems with diabetes and cardiovascular disease due to food manufacturers having replaced salt with sugar.

Idleness is updated to inactivity, in the modern world there is the lack of physical activity and addiction to screens. Getting people moving has massive benefits for their health this is something that public health is addressing through the One you campaign and apps like Couch to 5k.

On top of these five giants, we have disease that in today’s world has become illness with its multimorbidity and polypharmacy. Comorbidity is the name of the modern healthcare game, but it feels as if public health in some regards still has a single-disease mindset of the past.

We need still need to address the five giants but not on the historical health determinants, we need to redevelop them and tackle the five giants looking at what has changed at the start of the 21st century.
Take primary and secondary care. For us as an ambulance trust, our two biggest demand areas are mental health and falls; that makes up over 25% of our activity – mental health about 10% and falls 15-20%, most of which are in the frail elderly population.

If we took a non-traditional service approach to this, it would be a question of how as a provider we could get into helping frail older people not to fall through home welfare checks. In mental health, it could be seeing patients through things like the blue light partnership, and using a street triage car to address those who come in to any of the 999 services.

We as a system need to go after some cost-effective no-brainers, which has to include tackling obesity (and I include myself in this!). This must be our real number one target: obesity and its issues. People need to see that as they pile on the pounds to their waistlines, they pile billions of pounds of avoidable costs onto the NHS. So we need to reduce sugar in processed foods and help people in an effective way to make healthy diet and exercise choices.

Another public health need that we know is going to hurt the NHS is frailty. How can public health help support reducing frailty? We know that the 70-year old baby boomers are starting to come through the NHS, and social care reductions mean that there’s nothing in place to think about how to keep our growing older population healthy and well. So we have things in place to pick them up in crisis and get them back home after a health event, rather than prevent it. That’s expensive and unaffordable now and forever.

Too frequently, the NHS is still only a national illness service. Our advantage of being a regional provider sat across six sustainability and transformation partnerships (STPs) is that we can see the good, the bad and the indifferent. Our partners range from STPs who get population health and talk to public health consultants and set up workstreams to deliver what is needed. Other STPs doing less well are focusing on services to treat the ill (frailty or acute), not on what the needs of their population are and will be in future nor on how to treat early or stop people from getting ill in the first place.

It’s a misconception that all STPs are using population health knowledge and skills to plan services: the STPs who are not working well are missing out this vital element of healthcare planning.

Finally, we have to think about prevention and how payment systems work in the NHS. Our current system doesn’t leave anyone other than primary care wanting to reduce activity – funding is still mainly clicks of the turnstile coming in, not rewarding organisations based on those not coming in. This is true for commissioners, community, mental health, ambulance and acute trusts. Funding does not incentivise us to develop
and agree how we can work together to keep our population well while still doing the right provision activity. We need a big focus on appropriate incentives to keep the population well.

*Making every contact count* is a nice idea and phrase, but in practical terms, it’s died a death. People need to think about this: if you want accountable care systems to work, then you have to create incentives to keep the population well, and not just pay for illness.

Too frequently, the NHS is still only a national illness service.
In the 2012 Lansley NHS reforms, moving most public health functions from the NHS into local government did reflect the evidence on where the basic determinants of population health can best be influenced. Despite many tricky transition issues, such as changes to some data flows and problems with melding NHS and local government cultures, I supported that change in principle, and still do.

Of course, money’s an issue. Although growth in local government public health budgets was biggest in the first two years after 2012, that funding growth then stopped and is now in reverse.

**High expectations, low resource shift**

I still believe the principle of public health sitting in local government is right, but it’s tough as resources dried up and expectations about what can be done with those resources have increased, especially with the *Five-year forward view*, the new models of care and sustainability and transformation partnerships’ (STPs) emphasis on place-based approaches.

These are all good principles, but expectations are sky-high, and the risk is that public health won’t be able to cope with what it’s expected to do. Many STPs have warm words on prevention and moving upstream, but resources are not following at present.

The money has dried up in local government, less so in the NHS although it’s more opaque as there’s less transparency on the detail of the NHS’ public health and prevention funding and spending.

The boss of Public Health England (PHE), Duncan Selbie (see page 47), is clearly keen on the public health role of local government, but we’ve almost turned our back on the NHS role. Each pound spent in the NHS on treatment could simultaneously have a role in prevention and in addressing the wider determinants of health and broader constructs of social value. We need to make that work better.

**The NHS as economic player**

We’re only at the beginnings of thinking about the NHS as an economic entity as opposed to a mechanism of delivering treatment, and to some extent prevention. But the NHS is a massive economic and corporate social institution, which makes an amazing contribution to the UK economy: one we under-value, under-celebrate and fail to make the most of, within whatever budget envelope it has. This isn’t about more money, but spending it with a better eye on the overall effects on health.

For example, the OECD in 2006 looked at sectoral fiscal multiplier effects, and found health spending was one of the biggest, it is a contributor to
The NHS is most comfortable with prevention when it is working with those who are already ill or at high risk.

The NHS is most comfortable with prevention when it is working with those who are already ill or at high risk.

wider economic growth. The NHS is also a machine that narrows income inequalities and thereby health inequalities.

We have one of the widest income inequalities in the developed world, and if the NHS were not here that would be about 15% wider than it is now. But nobody knows that or is really thinking about how this impacts on health. There’s an income-reduction, poverty-reduction, virtuous circle to be had if only we realised it and understood it. The NHS therefore should not see itself as just a reactive passive responder to these economic factors that drive our health, but a proactive player in helping to solve and tackle them.

What needs to change?

First, rethinking the NHS as an economic driver in our communities and therefore its contribution as above. But we also know a lot about what needs to change through prevention and treatment. Some of my time working at the Department of Health (I left in 2011, as we got into the coalition) showed me that we understood a lot about what NHS prevention could do (secondary/tertiary prevention) to meet the last Labour government’s health inequalities target. Those targets got dropped. But we had, and still have, the knowledge developed at that time on what we do in the NHS now – cholesterol control, diabetes control, smoking cessation – simple lifestyle support stuff. We know it works – a recent paper by Ben Barr and colleagues\(^1\) has shown that this was associated with a narrowing of inequalities in life expectancy – so why are we not doing it at scale and systematically across the NHS? In particular, we still don’t do that for the harder to reach, more disengaged people who may miss appointments if they have complex, chaotic lives. If we did, we would have a vast impact on quality of life and life expectancy. It’s good to see PHE’s recent tools on this, updating and refreshing those that supported the old target. But it’s an open question for me about whether we have the performance levers, or corporate memory, to actually implement them.

The challenge of the obvious

The NHS is most comfortable with prevention when it is working with those who are already ill or at high risk. one important goal must be to do this far more coherently and systematically than we do.

We also need to define the NHS role in supporting local government, which is definitely struggling with resources. If we’re talking true ‘partnerships in place’, how do the sectors’ budgets line up?

\(^1\) www.bmj.com/content/358/bmj.j3310
For example, a recent National Audit Office review on public sector reform found local authorities were doing lots of heavy lifting and spending cash on reform, while the NHS was the sector benefitting in terms of demand reduction. Some of the budgetary savings need to make their way back to local government to maximise the incentives to keep investing. One disappointing signal, after their rhetoric about a radical upgrade in prevention, was NHS England’s attitude on PrEP (HIV prevention drug pre-exposure prophylaxis), saying we shouldn’t fund it as prevention is local authorities’ role. The courts rightly ruled that just because local authorities have new powers in this area, it doesn’t mean the NHS should walk away. This lack of coherence and dissonance between rhetoric and reality from the top is a real challenge and barrier.

More specifically, research and practice are now showing that while our focus on frail older people is good and important, we’re starting to see signs of the frail young, most obviously in homeless populations, which are growing but not yet huge, fortunately. We know the connection with multimorbidity: poverty means people get health challenges 10-15 years before wealthy populations. How is this being addressed in STPs and similar local plans? I don’t see much evidence that this is on people’s radars, and it should be.

As for any cost-effectiveness approaches that people in the NHS and local authorities should consider, they should look at past and present work on behaviour change and ‘nudges’. We know that smoking prevention and cessation are ‘best buys’. But we see worrying signs that resources in these areas are falling, partly as a result of the overall cuts to local government public health budgets.

On lifestyle more widely, we know that most people (7 in 10 adults) don’t adhere to key government guidelines in two or more areas around alcohol, tobacco, diet and physical activity. We therefore need to move on from seeing lifestyle change and services as just behaviour x, or behaviour y and help people tackle a range of challenges over the long term. The challenge – and possible win-win – would be local authorities and the NHS asking the public what behaviour support/change services they’d like co-located to enable the prevention agenda. We are starting to see some good models on this in terms of integrated health and wellbeing services and will be publishing some work on this later in the year or early next.

And of course, there’s digital health. Most people talk about how digital could make the NHS more efficient – no bad thing. Then they talk about apps, messaging and channels. That’s no bad thing either. I think of the more exciting work The King’s Fund did with Demos, a social policy think-tank, earlier this year on how people talk about health, we looked at a million internet posts on mental health to test whether we could make
sense of this vast, rich, but essentially unstructured information. Although
there were lots of issues, essentially the answer was yes.

So this sort of information could be a ‘third space’ for understanding
mental health issues and how they interact with daily lifestyle conditions
like diabetes. It could also give us leading indicators about how people
perceive services, and other emerging issues in the system. There’s
immense potential in using these online conversations for understanding
the experience of health. There are of course challenges around the
sensitivity and specificity of meaning, and of course lots of ethical
issues in using this information. But there’s big potential, especially with
machine learning.

All these things, together, offer the potential to rethink how we deliver
behaviour change in local authorities and the NHS, to support people
for longer when that’s needed, and to segment the population more
creatively and thoughtfully. This could save money and deliver longer-
term benefits.

Finally, when there’s no more money, regulation starts to look more
attractive, even to an anti-regulation government. We know the public
are willing to accept some forms of regulation from central government
and more locally. We also know that some parts of the food retail industry
want the government to do more, to help them compete on wellbeing,
not just price. It’s a challenge and an opportunity also for local authorities,
who have permissive powers and statutes to help them support local
wellbeing. I’m sure we will see more experimentation from them in the
next few years.

To conclude, I think we actually know far more than we think we do
about what is likely to work for prevention and public health. The
challenge is to act coherently across place, with the appropriate mix,
and resourcing of the social and medical models of health. The NHS,
with its partners, need to think more of itself as custodian
of people’s health in a place, and to use all these levers
that are available to them with the consent and active
participation of the public. While we talk about the culture
of systems and the leadership required, we tend to mean
NHS systems, and we need to break out of that to make
the most of the opportunities above.

We actually know far more than we think we
do about what is likely to work for prevention
and public health.
Public health’s overall purpose is to protect and improve the health of the nation. Before I became chair of an NHS trust in 2014, I was a public health consultant in the NHS for many years, and held very senior roles at regional, national and local level, and also in academia.

Part of the skills public health consultants develop during their training is the collection and analysis of data. When these consultants were employed by the NHS, their data analysis skills allowed them to advise boards and guide policies on healthcare decision-making. Since public health moved into the local authorities, this has left a gap in public health expertise at NHS trust level.

The intended benefits of moving public health into local authorities have not come to pass. This is in part because council budgets have been restrained and public health budgets have suffered cuts. It also takes a while for experts to learn the new politics of working in a local government setting. Public health’s influence has also been weakened, as it is now a less senior role than it was in the NHS, and no longer operates at board level.

### The public health agenda

At national level, public health expertise helps to shape government policy in areas such as education, housing and employment. It also promotes campaigns that address diverse issues such as health inequalities, contraception, addiction control, and smoking and eating habits.

The best example of a sustained public health success that I can think of is the vaccination and immunisation programmes of the early 20th century that succeeded in controlling diseases such as smallpox and polio, and more recently measles, mumps and rubella. These successful programmes had key ingredients to ensure their goal was achieved. All had continuous public health expertise, resilient leadership and technical competence to ensure programmes were carried through, as well as good data to demonstrate progress against the goals that the programmes set.

Public health also shaped the national screening programmes for cancer and genetic disease. This expertise has also been used to arrange clinical services such as stroke, cancer, specialist and rare disease programmes.

It is unlikely the Department of Health could have defined the appropriate constitutional standards we expect providers to adhere to without the input of public health experts.
Improving local health statistics

As pointed out by Simon Stevens in the *Five-year forward view*, the economic prosperity of Britain depends on a radical upgrade in prevention and public health. A strong voice is essential to keep these public health ambitions at the forefront of health and healthcare decision-making, but the local authority health and wellbeing boards that are accountable for local public health policy are still struggling to have an impact on our patients’ wellbeing.

In my patch many people have shorter lifespans than elsewhere, and our poverty and unemployment levels are above the national average. Increasing numbers of children and the elderly bring multiple chronic disease challenges that we have to deal with every day in our hospitals. To overcome these endemic problems, we need experts to guide and oversee a continuous public health programme. Only then can we improve local health statistics.

Missing: public health ethos

We tried, but failed, to recruit a director of public health to advise our board, our executive and our staff. The feedback we received from candidates was that these were now unusual posts in the NHS and that there were better opportunities available to them outside the NHS. Without this expertise, our board decision-making and staff and patient behaviours lack a much-needed public health ethos.

The trust as a health champion

As the guardian of health standards in the locality, our hospitals promote a smoke-free healthy behaviour. The campaign was led by one of our respiratory physicians and supported by the communications department, who marketed the campaign to staff and patients, and who recruited local newspapers to support the campaign.

Despite a lack of financial support from our local authority’s public health budget, we are nearing our goal to be 100% smoke free. Previously tobacco smoke drifted into the special-care baby unit and into the canteen where people were eating.

Other welcome changes were also implemented. Our smoking shelter became a fruit stall; our hospital site was redesigned to encourage walking, running and cycling pursuits by our staff; and our open air gym was opened to our local communities.

Better food choices located near to or just outside the hospital entrance has helped to discourage smoking onsite and has fostered better eating habits. Although funding cuts in local government impact on the extent
and type of preventative activity we can adopt, having smoke-free hospital sites is a no brainer if the hospital is to be a symbolic health exemplar to the patients, families and communities it serves.

We have an important role in our day-to-day interactions to educate local people in health literacy, too. Our sites have an enormous community footfall on a day-to-day basis. We use this opportunity to interact with our patients and their families by talking to them on a one-to-one basis and through the use of visual displays.

We are also sponsoring a local university technical college that will give local young students an education in health and social care. This could lead to a career in that field and give them a greater insight into healthy lifestyle choices. We also hope that this cadre of young people will be able to influence their families and peers on good lifestyle choices.

The cost of local authority cuts
Funding cuts by local authorities mean that support services designed to keep patients at home are no longer being provided. This means that more people are coming to A&E in a state of crisis.

We know that in the home setting and in the care homes local to our trust, residents develop pressure ulcers that quite rapidly deteriorate to grade four. If residents were being visited by support services then the pressure ulcers would be spotted before they deteriorated. Our chief nurse is leading the drive across the patch to try and resolve this unfortunate state of affairs.

Another issue we are trying to improve is the number of mostly elderly patients we see in A&E that have had a bad fall. We are working with the local authority and the neighbouring community trust to raise awareness and find mechanisms to prevent these falls.

Some people might not see these issues as public health activities, but attention to these areas are important for the wellbeing of our community. By not addressing these issues, the trust has to deal with more acutely sick patients in a crisis setting. This is a sign that the public health expertise in local authorities is not as effective as it could be.

Up-to-date data needed
The recent development of sustainability and transformation partnerships (STPs) provides an opportunity to revive and restore public health as a local force for good, but STPs currently lack the public health depth of knowledge, expertise and skills needed to do so.

STPs should be a forum for bringing together all interested parties so that good practice in public health policy in the interests of health gain can be made.
Public health expertise would enable STPs to consider which public policy issue is the priority. If deployed well, public health could support the health planning process, influence decision-making, and help to evaluate service redesign across trusts in the region.

To be effective in the STP regional setting, public health programmes need to be continuous and have sufficient expertise to collect and conduct real-time data analysis. This expertise would be useful for interpreting demographic, mortality and morbidity data, and for monitoring infection control. It would also be useful when assessing clinical effectiveness and outcomes across the trusts in the region.

Another use of this expertise could be to design health support mechanisms that are sensitive to local groups who do not follow traditional health access routes. This is important because, as the statistics show, these groups are more vulnerable to ill-health because of poor lifestyle choices and health risks.

**Communication**

To take part in a grown-up dialogue about illness and health behaviours, the public needs to understand what good health behaviour is. Somehow we need to get these messages across in a way that the public can relate to, something we have not properly achieved to date. We must also stop confusing patients by using NHS acronyms when we speak to them!

For instance diabetes is a disease that many people face. Cuts in the skin of elderly diabetics can develop into ulcers and possibly lead to amputation. If we could get elderly diabetics to understand this risk and, for example, get their toenails cut regularly, then this would reduce the risk of amputation.

The messaging also needs smart communication tools, such as social media and videos, to generate experiences that people can interact with and learn from. The stories need to be insightful, relatable and personal.

**Takeaway message**

Please use public health wisely. The aim of public health is to improve health and lighten the burden of illness that society faces. It does this best when deployed well, and when it is not withdrawn from important health and healthcare programmes until the goal is achieved.
Moving public health into local government is a very positive development. The timing however was difficult, with the sector severely hit by the austerity programme.

However, the cash crunch enabled local government to really look at ways to transform what it does: in that sense, it created opportunities to look to innovate and do things differently, and gave a chance to step back and explore how to improve population health through all elements of councils’ work.

The opportunity factor
In certain councils, those opportunities have been really well used, and a lot has moved forward. But we mustn’t underestimate the enormity of the funding cuts, and the pace has meant that some councils have perhaps had less ability or time to explore how to develop new models of improving population health while using all the active tools councils have.

So the scale and pace of cuts has been a considerable challenge for local government and public health. The available advantages are opportunities for public health to work differently, and the countervailing risk is that cuts are of a scale and pace that is not necessarily beneficial to population health.

What’s very positive in the move to local government is the huge advantage in local government’s ability to influence real determinants of health, and we’re only just getting started on that journey.

Short term and longer term
It’s hard to give a score out of 10 on how the public sector, including the NHS, is delivering on the Five-year forward view’s stated expectation of a big shift to prevention. The financial challenges have too often led to a focus on short-term finances, and prevention efforts don’t always fit into short-term timescales.

When you need cashable savings, it is that much more difficult to prioritise prevention efforts. It isn’t easy, but taking a medium to long-term approach is really critical if we agree to tackle the major health issues our nation is facing at the moment.

The provider as preventer
In order to meet the scale of the health challenge, prevention has to be everyone’s business, it can’t just be about the public health grant.

What’s disappointing is the gap between the expectation – set up initially though the sustainability and transformation partnership (STP) process – of a major focus on prevention, and then the reality of what is in final
plans. Unfortunately, while there is some positive increased focus on prevention, it’s simply not being translated into the scale of prevention we need.

An STP change

The STP process acknowledges that much more prevention is needed through the NHS itself, and that the public is generally not sufficiently involved. Public health does get involved in the STP processes, but I’m disappointed that the funding is not there to implement what is needed. So much more could be done to improve efforts around prevention, be it primary, secondary or tertiary.

For example with alcohol-related harm, we have strong evidence on the benefits of alcohol liaison teams and targeted, focused efforts in acute and community settings, but unfortunately rather than scaling these up, they’re being cut back. That’s short-sighted.

As for smoking, I think every patient with a smoking-related illness should have access to a brief intervention and support to stop smoking: that should be standard across the NHS, as should encouraging healthier habits in physical activity and diet.

And we have to work with patients and communities to improve people’s understanding of their risk factors and what they can do to improve their own health and wellbeing. We need to empower them.

Thinking sustainably

For NHS providers, having public health sitting in local authorities can enable us to work together on exploring innovative ways to influence health determinants across all sectors of people’s lives, and to enable healthier choices to be easier. It means an opportunity to influence the high street, housing and schools.

A lot of NHS trusts are doing great work around areas such as healthy catering and reducing their carbon footprints, looking at how to create environments to enable healthier lives and make a healthy choice the easy choice for patients and staff. This is the NHS ‘doing’ prevention; and, with local authorities, we need to scale up our efforts across our places and our communities.

Hospitals are huge sites, and NHS England’s chief executive Simon Stevens has a good focus on trying to get healthier food and drinks on offer. Some trusts have policies on smoking, but we need to ensure every NHS site has a no-smoking policy, which is enforced, and provides proper support for staff, and patients, who want to stop smoking.

It isn’t easy, but taking a medium to long term approach is really critical if we agree to tackle the major health issues our nation is facing at the moment.
The NHS should support its own large workforce to live healthier lives. *Making every contact count* has to involve us all.

**Really understanding prevention**

I understand how important politically it is to prioritise efforts where there’s a strong evidence base. We should expect nothing less, but with public health having done this in our contributions to the STP process, I am unclear that funding has been shifted at all from treatment into prevention. We know that we need that shift from a strongly treatment-focused service to a *health* service so things are more financially sustainable in the medium and longer term.

Also, the very word ‘prevention’ can mislead – we do try to prevent illness, but why don’t we take an asset-based approach and say that we’re trying to enable longer, healthier and more fulfilling lives.

The best focus for a big public health effort? I think it would be smoking. The dramatic reduction in the prevalence of smoking is fantastic, and shows what a public health approach can achieve. However increasingly, smoking is concentrated in populations on low incomes, in those with mental health issues, and in certain communities. So that’s set to drive inequality in the life expectancy gap. Our variable approach to dealing with smoking is really not acceptable.

We need to ratchet up our efforts to reduce smoking: we can’t sit back and think we’ve achieved enough and ticked that box. We have to maintain really strong efforts to continue to push down smoking prevalence, especially in those groups where it’s high. It’s ludicrous that in the 21st century, so much harm is still evidenced by people with smoking-related diseases.

*It’s ludicrous that in the twenty-first century, so much harm is still evidenced by people with smoking-related diseases.*
It’s difficult to fully understand the intention behind moving public health out of the NHS and into local government in the 2012 legislation.

It appears to have led to five years of disinvestment in public health at a time when arguably that should have been the priority investment.

I’m sure that was not the intention. Maybe policy-makers didn’t see the local government funding deficit level coming as fast as it did. Either way, today, that move to local government seems like an unusual choice.

**Improving long-term conditions management**

Looking at the management of long-term conditions (LTCs) from both commissioner and provider perspectives, we nowadays talk much more than ever before about public health and prevention as vital parts of the LTC management plan. I always say that I want the preventative stuff bolted on to the front of any LTC management I commission. It’s a pre-investment, which should prevent or at least delay some spending further down the line by reducing the disease burden and therefore the need for treatment.

**Primary care is key to prevention**

The issue of investment is vital. Primary care has always had a key element of prevention: from weight management support to smoking cessation, healthy lives matter. The frontline generally gained support from public health colleagues in the primary care trust, or latterly the local authority, who could provide tools to support that health promotion agenda.

As commissioners, we now look more widely to other partners to support the prevention agenda, but with public health sat in local authorities, there’s a worrying disconnect between the two. As we move into the world of accountable care systems (ACSs) or accountable care organisations (ACOs) those kinds of disconnects are no longer viable or acceptable.

**Awaiting connection?**

It’d be fair to ask if these are real disconnects, or bits of the system that are simply yet to be connected. Clearly, innovations such as academic health science networks (AHSNs) for example, didn’t exist five years ago: now they are able to offer structure with a strategic approach, and involvement and engagement linking into the strategic commissioning and delivery of healthcare. The additional links with industry can be essential to support funding streams for preventative services, among others.
Some traditional public health components of the NHS system now sit within AHSNs, and we need to network this effectively, via the sustainability and transformation partnerships (STPs) and ACSs into more effective collaborative arrangements.

In Buckinghamshire, for example, we’re one of eight ACS pilots; we are trying to work together with partners to deliver the best outcomes for our population. Public health experts locally are key to our plans – they are very good on the determinants of health and local population needs analysis. In the broader sense, they understand what to do with our data in a preventative way to get better health outcomes.

STPs and AHSNs can be the network and glue between the service and industry. As a system, we’re establishing the public health resource that we’ll need to pull in as we reconstruct the jigsaw – we’ll have to use all the system’s resources for our locality.

**STPs’ effect and effectiveness**

The effect and effectiveness of STPs varies predictably, with issues such as geography and local relationships playing a part in this. As a clinician, I want a local population focus to understand and meet that local healthcare need, which implies a smaller geographical footprint, but a small footprint can make it too hard to commission properly or reshape provision meaningfully.

**The local and the national**

We need a balance, with some planning local, some broad-based – both are needed. And we shouldn’t commission in isolation of each other: STPs need to know about local demography from the frontline of primary and secondary care provision.

As commissioners, we now look more widely to other partners to support the prevention agenda, but with public health sat in local authorities, there’s a worrying disconnect between the two.

Clinical commissioning groups strengthened clinical leadership of local population health. Local authorities appreciate that clinicians understand their local population too. For STPs to make reconfiguration decisions without understanding that local knowledge and constituent components will be difficult.

I’m not convinced that the prevention agenda can solely be delivered at big geographical footprint level. We know that the big ‘don’t’ messages that now sit with Public Health England (don’t smoke or eat or sit too much) are more effective alongside community delivery of public health messages.
Providers and prevention

Then we have to link public health prevention into providers and how they’ll work to deliver and help the system promote preventative medicine to keep NHS services sustainable for the future.

This will mean changing payment methods: not removing the purchaser-provider split, but weighting more incentive away from payment-by-results style activity to help providers work with the rest of the sector to defer or reduce the activity we have to deliver down the line.

Historically, commissioners talked to providers to collectively deliver the services their population needed within budget. In an ACS world, we need to make sure those outside that thinking, particularly providers, come to the public health party. Our aim is to decrease the burden of LTCs by highly effective, motivated investment in preventative medicine as we haven’t done ever before.

I am relatively optimistic that if we can get people to understand that argument, it’ll work. Because I don’t think it’s an option to fail. Look at the gradient of life expectancy in the last 70 years, as the NHS has grown and delivered! It’s fantastic, but it’s being outstripped by our healthier population living longer with conditions that cause morbidity. The burden of disease bites back.

One final thought: we’ve run the health system in 12-month fiscal cycles for decades – it’s no way to deliver population health. It makes no sense to run a £110bn-a-year business in 12-month cycles, so we need the bravery to talk about how we’ll invest for the future to get a public health return.

STPs need to know about local demography from the front line of primary and secondary care provision.
The Five-year forward view has fine words about population health, public health and prevention being real priorities. So how will it deliver on its rhetoric?

As a scientist, I start by looking at the evidence on how well we do on these things when compared with other countries. We don’t do very well for women, and we’re mid-range for men using life expectancy as a simple (if not the best) measure of health.

My view, which I’ve expressed for years, is that this relatively poor performance for an affluent nation is not just about the NHS, but about how we organise our affairs in society. It’s a fact that we’re not at the top of the health league: why do we accept that we’re middling? I’d like us to be a shining beacon for other countries, and we’re clearly not.

I relate that to public health generally and to the basic determinants of health, not just to what people with job titles that say ‘public health’ do.

A question of social action

Public health is everyone’s business: central and local government, the health service and the third sector. Now, ‘everyone’s business’ can be taken as ‘it’s up to individuals to look after themselves’, which is not what I think.

Really, it’s a question of social action. Individual behaviours matter enormously, but they are influenced by and conditioned by environments and social determinants.

To each not according to their need

The impact of local government’s considerable funding cuts since 2010 and the consequences for public health, prevention and population health activity has to be set in a broader context. In the 2010 Marmot Review, I looked across six key domains, developing recommendations and considering future challenges. Since then, we’ve seen severe cuts to local governments’ grant from central government, and in general we’ve seen the bigger cuts in those areas with greater need as measured by deprivation. So needy local government areas have been cut more than less needy ones.

A grim five-year forward view for poorer families

Looking at my first domain of early child development, the Institute for Fiscal Studies, when looking at the 2015 budget and projecting forward

---

Michael is professor of epidemiology at University College London, and president of the World Medical Association. He led research groups on health inequalities and is engaged in several international research efforts on the social determinants of health. He was knighted for services to epidemiology and the understanding of health inequalities.
five years, said that families with children would be hard-hit and those on the lowest income hit first: the bottom income decile face a 10% cut in their income; the next lowest-income decile facing a 12% cut, then as you go up the income scale, the hit is less and less. The general fiscal climate is likely to make poverty worse for families with children.

At the same time as we need national fiscal policy there must be local action. Here, we have the bad news of cuts to local government funding, so many Sure Start centres have closed, leading to lower capacity for local government to support a family with children. But the good news is that in our recent report\(^3\) we found that London narrowed the gap in early child development for poorer children (defined as receiving free school meals).

The second domain is education. The London effect for early child development is also seen in education. We know that youngsters with free school meals traditionally do worse at GCSEs, but London has narrowed that attainment gap dramatically.

There had been a proposal to cut funding in London, as this showed it to be doing fairly well in budgets, and reallocate the money. I say, don’t cut London for doing something right! Work out what they’ve done right, and bring up the rest of the country.

The third domain is employment and working conditions: the recent Taylor report\(^4\) on the gig economy should concern us all about the nature of working environments, especially for our young people not in education, employment or training. We’ve seen some progress there, which is good, but it’s vital that be kept up.

The fourth domain is having sufficient income to lead a healthy life, and the trend here has been adverse. I quoted the Joseph Rowntree Foundation study\(^5\) that “the proportion below this income threshold in 2008-9 was 25% living in households with income below that minimum standard; and by 2014-15 it was 30%.”

So clearly that’s gone up, and the average incomes of employed people are not yet back to the 2007 pre-financial crisis level. Having insufficient money to lead a healthy life is clearly important. In this year’s general election campaign, we heard a great deal about NHS nurses having to use food banks.

The fifth domain is healthy sustainable places to live and work. Two words – Grenfell Tower. This towers above the whole issue of healthy places.

---

\(^3\) Institute of Health Equity, Marmot Indicators Briefing, July 2017
It’s good news that petrol and diesel cars will be phased out by 2040, but there was a disappointingly huge fuss on local authority plans to limit air pollution.

The final domain is that of traditional public health – smoking, obesity and diet – and the reduction in the budget for Public Health England and cuts in spending by local authorities is of great concern.

But my point is that all of this is of concern right across the board.

Health equity

The question of the appropriate role for the health sector in prevention and in population health is interesting. During my year as president of the World Medical Association (which ended last October), working with my colleagues at the Institute of Health Equity, we had a mission to interest more doctors in health equity. We produced a report: *Doctors For Health Equity*\(^6\) which highlighted five key areas.

Education and training is obviously important, so too is seeing patients in their broader social perspective. My UCLH colleagues who founded Pathway Community Interest Company argued that healthcare professionals shouldn’t just treat homeless people and send them back on to the streets: you have to support them as a managing individual, and help them to find somewhere to live. I’m greatly inspired and cheered by such initiatives.

We also considered the health service’s role as an employer, and how staff feel about their working lives. The NHS provides a good deal of good-quality employment for women, which empowers them and improves their quality of life.

There’s also the importance of working in partnership, and Lord Low’s Commission talked about primary care as being an excellent place to help people access a wide range of social services. Famously, Sir Sam Everington, my cousin Saul Marmot, and their team in Bromley By Bow Centre do about 80% social prescribing. Finally, we highlighted doctors’ roles in advocacy for our patients and the populations we serve.

The development of sustainability and transformation partnerships (STPs) provides a moment for us as a system to reflect on how we can use them to revive and restore population health as a priority. I’m an optimist, and I don’t do cynicism (or only very badly): in my view, STPs offer us an excellent opportunity to transform the ways in which health and care go about trying to improve the health of their patients and populations, and they are a smart way of looking at the health and care economy’s broader impact.

---

\(^6\) Institute for Health Equity and World Medical Association, *Doctors for Health Equity*, 2016
Slowing growth in life expectancy

My recent report on life expectancy found that over the last 100 years we’ve seen a steady improvement, which has slowed since 2010 in the UK, and the rate of increase has about halved. The mean has been about a one-year improvement every three and a half years for men, and for women one year every five years. Since 2010, for men it’s been one in six and for women, one in ten. Why is this? We can only speculate, but there are two broad types of explanations. First, we regularly report on the social determinants of health inequalities. The six domains of the Marmot Review, acting through the life course, are having this effect over time.

But we should also ask about contemporaneous effects. Did something change in 2010? Since 2009-10, our spend on the adult component of social care has gone down by 6.4% when our 65-years-and-above population increased by nearly one sixth. Since the late 1970s, spending on the NHS increased by about 3.8% annually in real terms. Since 2010, that’s been 1.1%. And our population is growing and ageing, so care needs today are likely to be greater.

Dr Sarah Wollaston also cited data that real spend per capita is set to fall next year. So we have less adult social care spending and a reduction in NHS funding below the historical trend, in absolute terms, and an ageing population. All of that is likely to have an adverse effect on quality of life.

I was asked three times to say that austerity was causing this change in trends in life expectancy, and I said that we don’t know – but austerity is likely to have an adverse effect on quality of life. But whether it has an adverse effect on length of life, I honestly don’t know.

I don’t have one single recommendation for a change to improve public health. Perhaps people should look at the example of Coventry, which declared its intention to be a ‘Marmot City’. They plan to take my various recommendations, and in partnership with local government and the NHS, implement them across all the domains.

There’s not just one that is the most important: these things are interdependent. Where will the money for this come from? We could try using a thing called tax. We as a society have to decide how we want to spend our money, and if these things that I’ve mentioned are chosen, that would seem to mean making good choices, which are likely to have a positive impact on health and reducing health inequalities.

So if I’m forced to pick just one concluding recommendation, then it’s this: put health equity at the heart of all policy-making.

7 Institute of Health Equity, Marmot Indicators Briefing, July 2017
The big message is this: we lost something when public health population medical expertise was taken away from the NHS. We’ve lost the strong drive at commissioner level to keep prevention high on the agenda but also an understanding of how to deliver the best health services.

The loss is to our detriment. When I worked at that level and did the talking you knew you’d get a hearing for evaluation and for population health medicine as you also helped deliver core managerial and organisational priorities. This gave chief executives and non-executive directors confidence when public health issues were discussed at the boardroom table.

Recreating population health perspectives

Somehow, we have to recreate this understanding of the health of the whole population, and not just that of individual patients at every board table.

While some very vocal GPs argue that they do population health, it’s wrong. The average size of a GP list is simply too small for an effective population health perspective, so we don’t get the really well-considered service planning that we need and are over-influenced by the patients that are seen. Milder mental health problems for example, trump severe and enduring problems which are seen much more infrequently.

NHS England’s public health gap

So how can NHS England as the lead commissioner of specialised care not have a senior population health medicine expert at the board table?

Sure, the Five-year forward view talks a good game about population health, public health and prevention, but we’ve got to remember that prevention is a whole set of things.

People now tend to talk about what we used to call primary prevention – telling people how to avoid risk factors that lead to disease. It’s important, we need it in schools and jobs and everywhere people in daily life spend their time. We do not necessarily need facilities on hospital campuses which are remote from people’s day-to-day life.

The problem is that when you’re asking all the population to make small lifestyle changes, for many people, the benefit is offset far away in their future. Of course we should encourage exercise, and good lifestyle, but that will only make a big impact in 10-20 years’ time. Primary prevention alone will not deliver the financial savings in the next few years when we need them most.
Health service prevention

Health services are involved in other forms of prevention. Screening for cancer and hypertension for example aim to identify disease before symptoms occur (secondary) while health services in general aim to reduce the harm of existing disease (tertiary). We forget this at our peril. Good services, advice on weight loss and potentially surgery for obese people with blood pressure and type 2 diabetes can lead to rapid short-term gains for people and to reduction in demand and costs. This is the very practical stuff on how to prevent deterioration that is the day-to-day work of NHS clinicians. It’s not either/or: we need all these approaches planned and thought about simultaneously to manage the short and long-term challenges we face. I am saddened that I don’t see much of this thought and there is a dearth of proper economic evaluation outside NICE. We need to stop thinking that the only prevention is primary prevention. So where are the plans which integrate good advice on diet and cookery, advice on weight loss and the appropriate used of bariatric surgery which can be incredibly transformative?

Technology

We need to think more effectively about digital technology and apps etc – we know individuals in life relate to technology in ways we didn’t consider twenty years ago. There was a great story about a guy who got obsessed with Pokémon Go, and he lost four stone as he had to walk to unusual places to collect all the ‘characters’. That’s powerful.

We need to think about how to help young people use technology for health gain in exciting non-deadening ways. Too much public health messaging is boring, punish-y, “don’t eat this or that”. We need a school of social marketeers on how to encourage and nudge people effectively towards healthier decisions. Evidence from the ‘nudge unit’ has given us many clues of how to engage more effectively.

Rationing

And we need to think more clearly. Currently some clinical commissioning groups are saying no to hip/knee operations unless people are in such pain to be unable to sleep. This drives dependency as well as misery, both factors we know lead to more service use. Where is the preventive approach? With thought about the balance of weight loss advice and support and bariatric surgery we would reduce the need for orthopaedics but only if all three preventive strategies are integrated and properly funded. We can talk a preventative mantra, but it won’t mean anything without being backed by a massive preventative strategy.

The big message is this: we lost something when public health population medical expertise was taken away from the NHS.
Local council funding

Now that we are funding population health activity primarily through local councils, it should make us consider how council activity can deliver primary prevention: don’t smoke, don’t drink, eat well. This social movement will deliver long-term change, and cut rates of things like diabetes, heart disease and cancer. Local government is well placed to drive this – for example they can influence local education. That raises the issue of independent academies – and that’s why I think national government needs to put population-level prevention in the national curriculum as part of a long-term, joined up public health strategy.

But if I’m right, secondary and tertiary prevention is where short-term health and financial gains can come. We need to get to people at the point when they’re close to treatment and amenable to healthier living messages. What’s really happening to these services in local government? Drug and alcohol services, family planning are being denuded and have not been well-served by the move into local government. These services are at the interface between what we say to the whole population and how we give advice to individuals about how to mitigate health risk. Reductions in local authority spending impact on the types of services people need from the NHS and services have become disconnected. Many of the demands of the most chaotic mental health service users are linked to drug and alcohol use/abuse and it is the early support services that have been damaged. I see the NHS as being better-placed than local government to give the health advice to individuals and, for me, that’s the better fit. I think there is a degree of urgency in sorting this if we genuinely believe in a joined up preventive approach. Local authorities should do public health for the society-wide population level; the NHS should do public health for the individual.

Wales: lessons on ethos and scale

My time working for the Welsh government gave me a great close perspective on Wales’ reputation for having an effective approach to population health and prevention. The big advantage that Wales enjoys is scale. Nationally about 85 people manage 85% of public spending. Get them in the same room, and the collective action could commit 85% of public spending. The opportunities for place-based approaches are enormous. You can sit at the health board with all the people who influence and run things locally round a reasonably sized table.

Wales also has different political traditions that gave its NHS a more sharing, less competitive drive and allows Public Health Wales to be a strong, binding organisation, able to do decent work and agree things quickly. These structural and cultural issues of scale absolutely matter. We always go back and forwards: the NHS is either doing really big organisations or really small ones. My learning is that when we are too big we spend energy setting up sub-structures and when we are too small
we have to put our time into collaboration for big changes. Both levels are needed simultaneously and effective population health could help us get the right boundaries to drive change. We need to think about what we do locally and what can be run from afar.

**STPs**

This is why sustainability and transformation partnerships (STPs), if based on sensible geographical boundaries, have a real opportunity to do things better – it could get planning back to a manageable scale and give opportunities to revive and restore population health as a priority. It brings us back to needing population health expertise at the STP or accountable care systems/organisation table. The real benefit of this is not that they can write papers on population health: it’s the opportunities to have helpful conversations across the whole range of issues. Some local authorities send their directors of public health to STP meetings, but it’s not universally strong and well linked in to everyone’s detriment.

So let’s get back to a proper debate. Health services are not bad; primary prevention is not a panacea for the challenges of the NHS. A proper population and value-driven approach is needed now more than ever.
From an NHS perspective, we’re disadvantaged by the reduced role that public health as a specialty is able to play since the 2012 legislative changes. The amount of input public health specialists can now give at the local level in the NHS is extremely variable.

For people like me working in big provider trusts, rarely if ever do we see a public health specialist either as a provider or in commissioning meetings. I believe this means bad things for the whole system, as it weakens us in two main areas.

The prevention gaps

The first is in the prevention role of the NHS. Of course there is some great work going on – some fine staff health programmes, and good work on sustainability and community citizenship. Some organisations do put prevention into their care pathways – but it’s very patchy. Prevention needs to be more systematic, especially in provider trusts.

The second weakness is that where care pathways are being developed or refined, there’s now a significant lack of public health input into getting the most prevention/health gain out of the resources we’ve got. We need to both prevent ill health by getting upstream, and also have more effective care and treatment.

There doesn’t seem to be a particularly strong systematic approach and it all feels very piecemeal. This is particularly true of the systems approach to RightCare optimal value pathway work which requires a strong, coordinated and technically informed approach that clinical commissioning groups can rarely do on their own. This is just as true for care outside hospitals: the involvement of public health professionals and thinking in care pathways for local and community services (if it happens at all) sometimes comes down to the discretionary efforts of a local GP or consultant who champions this agenda. Of course, that means it’s often very variable by region.

Disempowering clinicians’ contributions

One obvious consequence of this is that when prevention or balancing the different aspects of the care pathway is considered in care pathway redesign, it’s often not implemented in the most cost-effective way.

A particular weakness is apparent in the way that doctors, nurses and other allied health professionals working in providers often feel very disempowered in taking part and contributing to decisions on what’s being commissioned – or decommissioned.

So public health specialists often get no opportunity to comment on prevention and value for money, especially in the work done within big provider units. To fix this, we need to see a consistently stronger...
population healthcare approach for trusts supported by public health specialists familiar with often quite complex healthcare.

This goes wider than just the prevention agenda, important as that is: it means promoting the leadership role of public health approaches to clinicians in trusts, and giving them access to actual possible solutions as a vital part of the conversation and the planning process. We think this is very important, and it’s not happening nearly often enough.

The cost-effectiveness question

The NHS needs to clarify its role in system-wide discussions about the cost-effectiveness of public health initiatives. There are things that council-based public health teams can and should do to make big changes, but our current system struggles when it comes to the NHS’ role in prevention and particularly in maximising Making every contact count.

Asking busy frontline acute clinicians to talk to every patient they see about smoking, weight, diet and exercise is impractical. Rather than try to ‘do it all’ in that way, we find that it’s more effective to train people to do one thing really well and to a strict evidence base. So our efforts in mental health targeted smoking cessation – a well-known problem of a huge health inequality in deprived communities with severe mental illness. There is a massive health benefit available here, but unless we really dedicate effort and time and training, then we struggle to achieve much change and we won’t make the difference we should.

The devil is always in the detail of how you deliver these interventions, be it for smoking, alcohol, or other brief interventions, but evidence continues to grow about successful approaches (a recent Lancet publication has shown that brief interventions for weight management can be effective8). The important basic principle is to be careful about what extra work you’re asking hard-pressed frontline staff to do – and when you’ve chosen what you’ll focus on, to do the work in small bite-sized chunks.

We also have much to do on the optimal value pathways for the ‘big-ticket’ areas like atrial fibrillation, heart failure and COPD. In these areas, there is potential for some genuine net cost savings, but I’m quite sure that these are not fully implemented in every place everywhere. As always, we need to do what we know works to the maximum. In other areas such as mental health, much more work is required.

8 www.thelancet.com/journals/lancet/article/PIIS0140-6736(16)31893-1/fulltext
A crucial element of secondary prevention includes getting specialist clinicians to actually comment on how effectively the money is currently being spent in their care pathway. If we do genuinely want to move efforts and resources upstream and into prevention, in some instances, we’ll need the specialists on board to help a really informed debate about how to balance resources across the care pathway. First and foremost, we need their help to ensure we identify all those with the relevant medical condition in the community. This is basic: support all stakeholders, including big provider trusts, to take a genuine population-healthcare approach once the responsibility for the catchment area has been agreed.

Matching supply to demand
Again, there could be some big gains to be had by doing this. Muir Gray describes the example that highlights what a system needs to know to be truly operating ‘population healthcare’: If we have a hospital COPD specialist who can see 300 patients a year, how do we ensure that the specialist sees the 300 patients in most clinical need, and not just the 300 who happen to navigate their way through the system to the clinic?

Many consultants tell me that they see some patients far too often, and others far too late: we have to fix this. Often, provider trusts feel relatively powerless to influence this. STPs could offer a genuine opportunity to address this shortfall, but they’ll need technical and community support to make it happen. Busy acute clinicians can’t go back to teaching patients about the basics of the determinants of better health. Public health specialists should play into that health literacy gap much more than they have. The limited Public Health England resources are excellent, welcome and much is available electronically but experts on the ground are sometimes needed to develop and help utilise these resources.

Whichever the area for which you are clinically and/or managerially responsible, think about how great it would be if you had the information to contribute to decisions about how care is provided, so that the available resources on your care pathway are being used to the best possible advantage of your population. That’s what the NHS has always tried to do but never has it been more vital to succeed.
The repositioning of public health in the 2012 legislation, moving it from its former seating in NHS primary care trusts to being the responsibility of local government, offered a real opportunity for public health to truly influence a wide range of things that determine population health.

This rather large focus on wider determinants of health contrasts with the more traditional tendency of public health sitting in the NHS. This wasn’t true everywhere: in our area, we had long worked closely with the local authority, and I was given a post as a joint appointment by the NHS and local government, so we had strong existing links. That helped us make the transition more successfully than may have happened in some areas.

Local government has a major influence on so many things that are key determinants of population health and wellbeing – housing, environment, education, employment – that it should become easier for public health thinking and approaches to have greater influence and impact.

Another benefit of public health now sitting in local government is that it’s physically far closer to the population than when it was sitting in the NHS. We’re more visible, closer to the population and to other partners like the voluntary sector.

One thing that will be vital to successful integration between health and social care will be to ensure that the voluntary sector’s offering is designed, networked and weaved into any offer we have.

The hidden healthcare system

I always describe the voluntary sector as ‘the hidden healthcare system that’s usually unrecognised by the statutory sector’. The voluntary sector is generally doing a very good job, but its work needs to be better integrated with the statutory sector.

So one of our key tasks is weaving the voluntary sector’s work into the jigsaw of health, social care and public health. Our aim must be that we essentially provide the right intervention for the right person at the right time in the right place. In doing this, we must also ensure that we move resources and services upstream and provide early intervention with a prevention orientation.

Repositioning public health in local government has helped do all of that, and allows me to describe my role as being the glue, putting all this together and coordinating the whole jigsaw and making sure that it feels coherent to users.
Practical value
Along with that, it allows me to work on all sorts of initiatives in wider determinants of ill health: in education, we’re working with schools, and we fund a universal free breakfast from the public health grant, which feeds 11,000 pupils in Blackpool primary schools.

This is an important intervention for a very deprived population with low income and high health inequalities, and by allowing us to ensure a healthy diet and educational attainment, will make a very positive difference: hungry kids don’t do well in school. This is just one example of how an initiative derived from having public health in local government allowed us to work with schools on something that will boost health and educational attainment.

We have to look at what would be effective interventions at lower cost. The key things we want to do are improve health, life expectancy, health literacy and reduce health inequality: all these are fairly long-term aspirations. For the NHS and the public health system to achieve these, it’s going to take a 10-20-year timeframe.

The *Five-year forward view* highlights public health and prevention, but we’re not going to see real progress on these within its five years. My thinking is that what we can achieve in a timeframe of five years or less is for areas to get that right intervention to that right person at that right time in that right place, regardless of who provides it and whether their badge says NHS, local authority or voluntary sector – the aim of our integrated offer should be that people are providing upstream, preventive services.

2020 vision
So my vision is that by 2020, we will have an offer for people where we’ve done the integration for them, and it’s not left for individual service users to do, as it often is now. We’ll have a workforce who are skilled in interventions, without hand-offs between organisations, and a seamless place-based public sector offer, regardless of who delivers it, for health, social care and public health at the local level.

That is all fairly low-cost stuff: it’s about using existing services in different ways. This starts off with my team doing a lot of bringing people and services together and mapping user journeys. For all the effects of austerity, there’s still a lot going on in our borough in statutory and voluntary sectors. We’re probably not making best use of what is already going on, and we could use resources better to make a better-integrated, place-based offer.

We have to get out of silo mindsets, and recognise that we’ll need a huge workforce transformation to work with different professionals in different ways.
One key area is quite obvious locally: we have such a bad health impact from substance misuse in our borough. We lose so many lives to drug and alcohol issues, that if we want to have an impact on life expectancy locally, then a key priority is to tackle this.

**Brisk approach needed**

We need lots of national intervention to help with this. Locally, we struggle with cheap alcohol in Blackpool. The fact that we’ve still not got minimum unit pricing is a big missed opportunity to have a big impact on alcohol-related harm. National legislation on tobacco has been far more effective: we have had tax rises, plain packaging, crackdowns on illicit contraband cigarettes, and the smoking ban. All of that has contributed to the big impacts we’ve seen in the significant decrease in smoking rates.

We need a similarly brisk approach with alcohol: to learn from what’s clearly worked with tobacco and use that approach for alcohol and obesity (healthy weight initiatives and more). The beverage sugar tax looks like a great start, but there’s much more to do, especially on marketing and regulation so we don’t advertise junk food to young people. These will have huge, measurable short and long-term impacts on the big health determinant issues. And we need a much better-integrated and upstream whole public sector offer, working together in a place-based and provider-agnostic approach.

Workforce transformation and organisational development will be vital to this. The way we operate needs to change. We have to get out of silo mindsets, and recognise that we’ll need a huge workforce transformation to work with different professionals in different ways. This will involve a lot of letting go and a lot of people gaining new skills – be it in specific brief interventions or in *Making every contact count*. Many people will have to move out of their professional silos and work in new approaches that deliver services and care in more integrated, user-centred ways.
Health is wealth – today in England, people who are affluent live around 20 years longer in good health than those with the least, with some of the greatest poor health concentrated in large parts of the north of England.

We know people are living longer, but often they are living in poorer health, struggling along with multiple long-term conditions. Half of people over the age of 60 live with two long-term conditions and a third with three or more.

The NHS has a critical role in treating illness and also in keeping people well. However, and notwithstanding having the NHS for the past 70 years, England has seen no significant change in the health gap between the affluent and the poor. The poor today are only now enjoying the level of health experienced by the affluent 20 years ago.

Reducing these gaps is at the heart of what matters most to the public health community and the work that Public Health England (PHE) does. This emphatically includes the NHS along with course with government, both national and local, the third sector, employers and individuals themselves.

This is why PHE was a co-signatory to the NHS Five-year forward view (FYFV) and its emphasis on tackling the health gap along with improving efficiency and outcomes. But those FYFV priorities are the same ones as I worked on with former health secretary John Reid 14 years ago.

At the time the NHS achieved an extraordinary transformation on removing waiting for care as the then day-to-day public experience and their number one priority for improvement. Having tackled this the NHS moved onto where the public concern next moved, hospital acquired infections and again achieved an extraordinary transformation. Remember those days of thousands of MRSA and C.difficile avoidable infections. Not so today.

We did not though, pay the same attention to health inequalities and it is this that the FYFV aims to address.

So what works if healthcare is important but not sufficient?

The choices people make matter. Whether to smoke, how much to drink, what you eat and whether you exercise. But even more so for good health is having and keeping a job, for children, a good start to life, young people entering adulthood ready for work and for adults, along with a job; a home and a friend. A job, a safe and warm home and someone to care for and about are the foundation of what works for improving health and closing the gap between those who are affluent and those who are...
not. In short, income drives outcomes and health and wealth are inseparable, spreading prosperity by creating jobs that local people can get.

These findings are evident in our Health Profile for England,\(^9\) which PHE published this summer, and is essential reading for anyone planning or delivering services.

The FYFV spoke to tackling the health gap, along with quality and efficiency and sustainability and transformation partnerships (STPs) are a step along the way to the NHS working with others to address this, and particularly with local government, who lead on education, planning and economic development as well as, of course, social care.

This matters to the economy too. As the population ages and more people are in the workplace for longer, keeping people well for longer becomes ever more important. Sick leave among working age people costs the UK economy £100bn a year and a third of this is explained by depression and joint pain. And about 330,000 people every year become unemployed because of health-related problems.

So what can the NHS do to help close the gap?

Where the NHS can make a difference is ensuring NICE’s evidence-based public health interventions are embedded as routine practice.

PHE have offered six interventions\(^{10}\) that are proven to work and are NICE approved that will improve outcomes, reduce demand and save money. If NHS providers chose to do just one or two of these interventions consistently over two to five years that would potentially save £1bn, and improve outcomes and reduce demand.

The most obvious of these is for the NHS to go smoke free. Smoking accounts for half of the health gap between the poorest and most affluent and helping people to quit remains the number one opportunity to address this.

Today in the NHS, 1 in 4 inpatients is a smoker and fewer than 1 in 13 of these has a conversation with a doctor or nurse or any healthcare worker about why this might not be a good idea. There are more than half a million tobacco-related admissions every year and for every smoker who dies early, 1 in 2, another 20 suffer tobacco-related diseases.

The ask of the NHS is to talk about this with every inpatient and to signpost the help on offer which is free. We would not leave three in

---

9  www.gov.uk/government/publications/health-profile-for-england
10  www.nice.org.uk/guidance/published?type=ph
four patients with pneumonia, for example, to sit in hospital without any treatment.

Then there are actions on alcohol, accounting for another one million admissions, on avoiding fractures by the frail elderly and on sexual health services.

Good health is about more than healthcare but the NHS has a big and positive role in keeping people well for as long as possible and to ensure that we play fair by everyone irrespective of income or circumstance.

John Reid, former secretary of state for health, once said to me that the NHS seemed surprised by winter. Not so today, but it might be said we are still surprised by inequalities in how we care for and about our patients.

*Smoking accounts for half of the health gap between the poorest and most affluent and helping people to quit remains the number one opportunity to address this.*
In the part of London where I live and work, we are blessed in the field of healthcare and research.

With Barnet, Chase Farm, Royal Free, University College and the Whittington hospitals – we have the highest proportion of ‘good’ ratings by the CQC in any sector of the capital. We also have some of the best mortality rates in the country.

We have specialist services of national and international pedigree. From sickle cell and thalassemia services at the North Middlesex Hospital and transplantation, immunology and amyloidosis at the Royal Free London to neurosciences at University College London Hospital, eye care at Moorfields and mental health services at the Tavistock and Portman. And of course Great Ormond Street – one of the world’s leading children’s hospitals.

Our health sciences are second to none thanks to our close working relationships with University College London – consistently rated one of the best universities in the world. Not to mention the London School of Hygiene and Tropical Medicine, Francis Crick Institute, Wellcome Trust and UCLPartners.

Population health needs

Despite the high quality of the healthcare and research infrastructure, we are still not appropriately meeting the health needs of the population. Two thirds of adults in Enfield are overweight or obese – as are 40% of children. One in five adults in Camden binge drink at least once a week and the same proportion in Hertfordshire smoke.

In the part of London we serve, the average resident can expect to spend 20% of their life not in good health.

Our assets and capabilities are clearly not translating themselves into better outcomes for our population – and the paradox is mirrored across the entire NHS.

I see the burden these kind of statistics are placing on the NHS whenever I walk the wards with doctors and nurses.

We need a seismic shift – not necessarily in the amount or quality of resources that are brought to bear, but how they are marshalled together.

System-wide solutions

We are starting to see a change of emphasis with the work of the sustainability and transformation partnerships (STPs) which is refocusing our attention on system-wide solutions and on population health – helping people to achieve their maximum potential – rather than treating people when they get sick.
In my experience, STPs are focused on achieving the triple aim of the *Five-year forward view*: transforming the quality of care we deliver, and working hard to achieve a clinically and financially-sustainable NHS – but doing this by taking seriously our responsibility to improve people’s health and wellbeing.

In the past, talk about prevention has been cheap. The practical challenge of implementation will take effort, energy and a serious shift of resources.

In our STP, the out-of-hospital care arena and primary care homes are bringing people together outside of traditional NHS structures. We are developing models based on populations of about 80,000 with health and social care collaborating on the best ways to meet the challenge. Affecting deep change in particular lifestyle factors is something we cannot achieve alone.

Those of us who work in hospital settings need to ensure patients’ physical and emotional needs are provided for; those who work in primary care need to take the same approach, and ask “is it clinically essential and economically sensible for this patient to be referred to a hospital setting?”

The Royal Free London is one of four trusts across the NHS chosen to develop a group model, enabling us to share services and resources more effectively across hospitals to improve the experience of patients and staff.

Our vision is of a group of hospitals which have the scale and partnerships to be commissioned to improve population health outcomes. If we can organise ourselves at a population-based scale then we stand a better chance solving our population health paradox.

**Key role of digital technology**

Technology will also have a huge part to play, if we let it.

The world has changed so much with technology pivotal to the way we all live our lives. There’s now an app for everything and we receive alerts on our phones with news and travel updates. Quite logically people now expect healthcare to take full advantage of the digital revolution.

As a Department of Health global digital exemplar, I’d like to think we’re leading the way in this arena.

We’re soon to be opening the most digitally-advanced hospital in the NHS – the new Chase Farm Hospital in 2018. And working alongside DeepMind, a Google artificial intelligence research company, our clinicians have developed an app called Streams which alerts our doctors to patients at risk of kidney injury in minutes. This is already having a huge
impact for patients, who get better outcomes, and clinicians, who save around two hours a day from not having to trawl through paper notes.

The big enabler for positive changes to health will be digital technology. We know that the expectations of our patients are higher than ever and in the digital age they want convenience, and expect data that’s bang up to date.

We need more data and less intervention. Around 80% of healthcare data is currently unstructured, and digital technology can help us knit this together.

We also need to have the vision to think about how digital can help us to afford our healthcare system in the light of rising demand. There are real opportunities to digitise many processes and drive out cost and inefficiency.

But I think the biggest challenge for us all is to change our mindset. We have to move away from hospitals being the symbol of the NHS to a world where empowering people to look after their own health is our primary function. And we have to think of our role as being about public health and population health outcomes, not defining ourselves by the organisations we work for or the buildings we work from.

“We have to move away from hospitals being the symbol of the NHS to a world where empowering people to look after their own health is our primary function.”
The positive side of where public health now sits in local government, following the 2012 Act’s reforms, is that the wider determinants of health are very much local government’s business. So I can see why that change seemed to be the right move: being able to think about the broader determinants of health and wellbeing makes great sense.

Sadly, the ongoing financial pressures on local government means this theory is not really working in practice. So we have seen significant financial pressures driving the tendering of public health services, and erosion of public health budgets.

This is happening just when everyone says this is one of the most important things to attend to if we stand a chance of achieving the Five-year forward view’s ambitions and changing the health outlook for so many of the public, especially the most vulnerable.

Financial impact

Financial aspects of local government have had real impact on services already: I worry that it’s only going to be more difficult in the coming years.

Where we have seen some mitigation of these risks to public health services is around the increasingly close working between health and local government in the work we’re all trying to do together around population health.

So, at STP and local delivery plan levels, we have a very strong focus on population and public health, and ambitious aspirations in changing the relationship between citizens and the statutory sector. This is driving us as leaders to think differently about people’s overall health and wellbeing.

Can this be enough to help us mitigate the full impact of the financial challenges for public health? I’m not convinced.

Driving innovation

However, the other thing that those financial issues has done is to drive innovation. I’m seeing more and more people recognising the benefits of the third sector and what they can bring, thinking about strength-based and asset-based approaches. This has always been one school of thought in public health, but we in the more traditional statutory sector now need new ideas on how to support people to support themselves.

From our perspective at Lancashire Care, we have long had a strong public health focus on early intervention, and employed our own public health consultant four years ago to help us think about how we organise and orientate services, and how staff practice in their jobs.
Our organisation has nearly three million contacts a year with a population of 1.7 million people. It’s almost a 50-50 split between physical and mental health. The vast majority of our contacts are in community settings, so we considered how to have a broader impact on people over and above direct care.

One very practical thing we developed was a training programme for all staff in Making every contact count (MECC). This training works at three levels; the first is a general awareness level, which is enhanced at the second level with specific training on signposting to other resources and support, and the third, highest level being more focused again. Well over 50% of our staff are now trained in supporting patients in the areas of diet, activity, smoking, adverse childhood experience and behaviour change.

Practical conversations about health change

We track how many times those MECC conversations are held, and see whether people are doing anything different as a result. Our figures for April to August 2017 showed there had been 58,000 conversations in relation to diet; 41,000 on increased physical activity and 15,000 each for smoking.

These are practical conversations on the ground, distinct to the regular previous practice of our staff. We think this is helping our staff practice their jobs in a meaningful public health way, be they a public health specialist or not. I think that is something for the wider health service to think about.

I’m sure that more and more NHS staff are doing this, but perhaps it’s not being systematically recorded in this way. Having invested in developing training, we thought it’s important to know whether our staff are using it, and what impact it is having.

Thinking around the whole person

It is also driven by a really strong both-way focus on parity of esteem. So our training has a concerted focus on people as whole people, with physical and mental health to consider.

We know about the significant physical health issues that people with mental health problems face, including the risk of significantly earlier death. So we look hard for opportunities to improve this: we focus on people with long-term conditions with significant mental health comorbidities. If we didn’t act on helping the whole person to stay well physically and mentally, we’d be missing the point.
We need people to really challenge their own thinking, whichever bit of the sector they work in – policy, service or practice – about people as people and in their entirety. They’re not just users of one service or bits of a system, they’re not just a diagnosis.

This is about thinking about people in the totality of their lives: not just biologically, but in their social setting – and about the factors that contribute to their lives and physical and mental wellbeing and health.

**Systems thinking**

Thinking around the whole person in this way takes you to different places and makes you think differently about what might be important to people. In particular, it should force you to think much more in a systems way, focused on individuals in systems.

One of the risks about all the current work on accountable care systems or organisations is that we get so sucked in to governance and financial flows and organisational form, rather than really thinking about what makes the real difference to Mrs Smith, who has different needs to Mrs Jones.

We have another example of thinking and working differently where we’ve co-located all our community staff in Chorley – a district council area in Lancashire – with the district council staff, who deal with housing, disabled facilities, grants and environmental health. If we focus on vulnerable communities and want to work preventatively, then we need to be much more upstream in their lives rather than waiting, as is traditionally the case, until the time vulnerable people start to urgently need social services.

We asked ourselves how our services can be really different from those people’s perspectives. So from this co-located joint working, we can pull in colleagues from primary care, social services and acute care. This started as joint work with the district council, and it really changes the conversation and makes us all as providers and commissioners think differently about how best to support people.

Another consideration is that while the wider determinants of health and early intervention and self-care all matter, there is a big public health secondary prevention agenda, which should involve the acute provision end of our world.

**Community prevention**

And there are very good examples of work looking across our STP in terms of stroke. A huge risk factor for stroke is under-diagnosis of atrial fibrillation. We’ve done some work, with our academic health science network’s support, using simple hand-held technology that pretty well
anyone can use to diagnose cardiac arrhythmia, and trigger a prompt to the person to see their GP to get treatment for their irregular heartbeat.

If this helps primary care to detect and treat atrial fibrillation early, that’s potentially got a really big impact. People think stroke care is all about where your hyper-acute unit is co-located and having A&Es set up for high-tech intervention, but this kind of community prevention – investing more in picking up atrial fibrillation in the general population and getting primary care to treat it well – is likely to save more lives than worrying about where to locate the hyper-acute stroke unit.

I’m not arguing that high-tech medicine doesn’t matter, but it’s a question of the balance of where we put our energies if we’re serious about changing our population’s future.

In the past, public health has been a bit of a minority sport: the domain of public health doctors and nurses and health visitors. In 2017, everyone working in health and care has a public health role to play. If we consistently start out from a public health perspective, we’ll probably make some different investment and policy-making decisions, and think differently about staff skills and competencies. And that will benefit us all in the long run.
NHS Providers is the membership organisation and trade association for the NHS hospital, mental health, community and ambulance services that treat patients and service users in the NHS. We help those NHS foundation trusts and trusts to deliver high-quality, patient-focused care by enabling them to learn from each other, acting as their public voice and helping shape the system in which they operate.

NHS Providers has 98% of all trusts in membership, collectively accounting for £74bn of annual expenditure and employing more than one million staff.

Read the report online
nhsproviders.org/provider-voices-public-health

Join in the conversation
#publichealth