Department of Health consultation – Healthy Lives, Healthy People: Our strategy for public health in England

1. I write with regard to the Department of Health consultation – Healthy Lives, Healthy People: Our strategy for public health in England.

2. The Royal College of General Practitioners is the largest membership organisation in the United Kingdom solely for GPs. Founded in 1952, it has over 42,000 members who are committed to improving patient care, developing their own skills and promoting general practice as a discipline. We are an independent professional body with enormous expertise in patient–centred generalist clinical care. Through our General Practice Foundation, established by the RCGP in 2009, we maintain close links with other professionals working in General Practice, such as practice managers, nurses and physician assistants.

3. The College welcomes the opportunity to respond to this consultation. In particular, we welcome the attention that is here given to public health issues, especially in light of the urgent need to tackle health inequalities as detailed in *Fair Society, Healthy Lives*¹, the report of the Marmot Review - though we note that this report identified a variety of social and economic causes for health inequalities that are not addressed

here. There are a great number of strategies detailed within the pages of *Healthy Lives, Healthy People*; it is not possible to discuss all these here, but the RCGP is fully committed to engaging with public health matters and we look forward to discussing many of these strategies further when they come individually for consultation.

4. We have limited our response here for the most part to the aspects of the proposed reforms that pertain particularly to the role of General Practitioners and the primary care team. This should be read in the context of our earlier responses to the consultations on the Health White Paper, *Equity and Excellence: Liberating the NHS*.\(^2\) We will also be responding to the additional consultations *Transparency in Outcomes* and *Funding and commissioning routes for public health*.\(^3\)

5. On the whole, and with the reservations outlined below, we are supportive of the intention to move the majority of public health functions into local authorities, to set up Public Health England for coordination of national activities, and to allocate a ring-fenced budget for public health. It remains to be seen how the proposed system will function in practice, and clearly much will depend on the willingness and ability of the members of local Health and Wellbeing Boards to cooperate and coordinate activities. We are confident of the enthusiasm of our members, both as consortia leads on Health and Wellbeing Boards and as individual practitioners, to participate in this vital agenda.

**General Practice and Public Health**

**Consultation question a: Role of GPs and GP practices in public health – are there additional ways in which we can ensure that GPs and GP practices will continue to play a key role in areas for which Public Health England will take responsibility?**

6. General Practitioners are, and will remain, at the forefront of public health delivery. The RCGP has described in detail the role of GPs in public health in its curriculum statement – *Healthy People: promoting health and preventing disease*\(^4\) - which also


provides a comprehensive list of learning objectives for GP trainees. Amongst many other matters, this document discusses:

- The GP’s lifelong and regular contact with patients, providing opportunities to discuss healthy living and for the early detection of illness. This can be related to the life-stages approach taken in *Healthy Lives, Healthy People*.

- The considerable experience and skills of GPs in managing multiple health problems to achieve optimal outcomes for individual patients with different socio-economic backgrounds. We note the emphasis in *Healthy Lives, Healthy People* on tackling health inequalities.

- The crucial role of health visitors in trying to address inequalities in health affecting young families. We welcome therefore the Government’s commitment to expanding the numbers of health visitors and urge that these be enabled to work closely with GPs.

- The role of General Practice in health surveillance – the generation of data regarding public health through bodies such as the RCGP Research and Surveillance Centre.

- The GP’s emphasis on patient-centred care, including enabling patients to manage their own care where possible and promoting healthy lifestyle choices, including in the areas of smoking, alcohol, drugs, diet and fitness described in *Healthy Lives, Healthy People*.

- The responsibility of GPs for the individual patient, his or her family and the wider community, and the importance of working with the wider primary and public healthcare team to engage in the public health agenda and influence health policy in the community.

7. We welcome the recognition in *Healthy Lives, Healthy People* that ‘as primary care professionals, GPs and GP practices play a critical role in both primary and secondary care prevention’. We believe more could be made of this, and greater emphasis placed on the role of GPs as the professionals with the greatest opportunity to influence patient and community health. For further detail and practical examples of how GPs can, and in many places already do, exert this kind of influence, we would direct the reader to the publication of the RCGP Health Inequalities Standing Group, ‘*Addressing Health Inequalities: A guide for general*
practitioners\textsuperscript{5} and the King’s Fund publication ‘Tackling inequalities in general practice’\textsuperscript{6}.

8. We note also the very important work of the Glasgow University ‘General Practitioners at the Deep End’ project\textsuperscript{7}, which brings together GPs working in the most deprived practices in Scotland to develop, share and disseminate examples of best practice and proposals to address health inequalities. The RCGP is currently developing plans, through members of its Health Inequalities Standing Group, to engage in related project work in England.

9. We welcome the opportunity presented by these reforms to develop and increase the commitment of General Practice to the delivery of public health. There are groups in society, such as the homeless and travellers, who notably do not access the healthcare they require and suffer greatly reduced outcomes. We will welcome any initiatives that support GPs in developing their work with these and similarly disadvantaged groups.

10. However, some GPs are sceptical of their potential to influence public/population health, and feel that there is a tension between health promotion at a population level and their primary role of responding to / treating the individual – that it may, in fact, in some cases damage the relationship with an individual patient. Recurrent challenges to patients about lifestyle can be seen as personal criticism and undermining of the struggles individuals face to overcome unhealthy habits. Public Health England would be well advised to develop coherent and persuasive evidence for the efficacy and level of specific interventions, to ensure ‘buy-in’ from clinicians and the effective use of their time and skills.

11. We note, as stated in \textit{Healthy Lives, Healthy People} that ‘GP consortia will have responsibility for the whole population in their area, including registered patients, unregistered citizens and visitors requiring urgent care,’ and also that Public Health England, the NHS Commissioning Board and local Health and Wellbeing Boards will be expected to coordinate with consortia in planning and implementing public health

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\textsuperscript{5} Ali A., Wright N, Rae M. Addressing Health Inequalities: A guide for general practitioners (RCGP 2008) - \url{http://www.rcgp.org.uk/pdf/Health%20Inequalities%20Text%20FINAL.pdf}

\textsuperscript{6} Hutt p, Gilmour S Tackling inequalities in general practice (The King’s Fund 2010) - \url{http://www.kingsfund.org.uk/current_projects/gp_inquiry/dimensions_of_care/inequalities.html}

\textsuperscript{7} Glasgow University – ‘General Practitioners at the Deep End’ - \url{http://www.gla.ac.uk/departments/generalpracticeprimarycare/deepend/}
}
strategies. We are concerned, however, that under the health reforms of *Liberating the NHS* GP Commissioning Consortia (GPCC) and local authorities are likely in many cases to be non-coterminous, making this co-operation far more complex. In essence, commissioning for public health will be a vital part of the GPCC role, but they are likely to be required to commission in line with the strategies of multiple Health and Wellbeing Boards and multiple Joint Strategic Needs Assessments (JSNAs).

12. Given the proposed abolition of practice boundaries and greater flexibility for patients to choose their GP practice\(^8\), it is likely to be the case that GPs will have many patients outside of the territorial area of their consortium, making it harder for them to commit resources to community-level initiatives. We have raised these and other concerns regarding the abolition of practice boundaries in our Briefing Paper on the Health and Social Care Bill\(^9\), and elsewhere. We would welcome detail and clarification of how this will be expected to work in practice. Cooperation between GPCC and public health teams is vital to the success of this whole agenda, and we would wish to see this formalised and made more explicit.

13. Under the proposals, GP practices will be held to account for public health outcomes, including incentives via ~ 15% of the QOF allocation. We welcome this, but note that currently many GPs do not feel they are very experienced in the area of public health, and do not necessarily understand JSNAs and the roles of other public health professionals. This responsibility will therefore place an additional training and education burden, which organisations such as the RCGP will seek to support. Coming at the same time as GP commissioning, with GPs taking a leadership role in healthcare and public health, this will affect not only current GPs but those training to be GPs. Extending GP public health, commissioning and service development competencies means that the case for extended training of GPs, which the College and others have been pressing for some time, is now stronger than ever.

14. We note also that the document does not consider the uses of GP-collected data, except its use for the more transparent evaluation of GP practices. This is regrettable; GPs have a vast number and range of contacts with patients, and the data generated by this can be of great value to inform public health policy. The work

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of the RCGP Research and Surveillance Centre (RSC), currently funded by the HPA, is regarded as leading the world in this area - It has data and baselines extending back for 50 years – this is unparalleled. RSC data is even recognised by media and public in respect of flu outbreaks and there is great confidence in this data\textsuperscript{10}. The unit and its work are relatively cheap and cannot be easily displaced (it is possible to collect routinely obtained data from general practice quite easily, but without the baselines and context, it is relatively meaningless).

Other Considerations

15. We are broadly supportive of the intention to give a major role for public health within local authorities. Some of our members have reservations, on the grounds that individuals without specific medical knowledge will be involved in planning for public health – others, on the other hand feel that involvement of locally elected councillors, with knowledge and interest in their locality, will increase accountability and engagement with local needs.

16. The proposal to maintain a ring-fenced budget for public health at both national and local level is very encouraging. However, public health can encompass initiatives in many diverse areas, such as transport, housing, leisure and education, so there is an evident risk of that ring-fenced funding being diverted or dissipated as financial pressures impact on local authorities at multiple points. There will need to be tight controls on the types of projects applicable for public health funding, and rigorous oversight from Public Health England. The risk, otherwise, is that diversion of public health funds will result in an increase in health inequalities – particularly as, in many cases, those local authorities with the greatest areas of deprivation are also those currently under the greatest financial pressure.

17. A danger, related to the previous comments and in the context of a White Paper with so many proposals operating at different levels, is of responsibility ‘falling between the gaps’ – that is, with so many duties shared between organisations such as GP commissioning consortia and local authorities, crucial initiatives may fail if no one body is held accountable for success. Much may depend on the proposed outcomes framework and its practical implementation at local level, particularly the facilitation of effective team working between GPs and other members of the public health team.

\textsuperscript{10} See e.g. House of Lords Science and Technology Committee – Pandemic Influenza p 38 para 6.39 (House of Lords 2005) - \url{http://www.publications.parliament.uk/pa/ld200506/ldselect/ldsctech/88/88.pdf} which
18. We have concerns, as with other aspects of the present health reforms, that there will be consequences in the transition process for the public health workforce. The proposed reforms will be dependent on the engagement and hard work of these professionals, and care should be taken that their status and working conditions are not unduly impacted in moving them into local authorities. In particular, we note that GPs currently rely on public health staff for epidemiological and data assessment skills. These will in the future be even more essential to assist GPs in effective commissioning and for analysis of sociodemographic variations in outputs of service. It will be highly problematic if GP consortia have less ready access to these skill sets.

19. We welcome the proposal to increase the numbers of health visitors to work with children, as this is a measure which may have a demonstrable impact on health inequalities, in line with the White Paper’s description of a life-course approach. However we would urge that, as with other members of the public health team, these be encouraged to work closely with primary care.

20. On the other hand, insufficient attention is given to the care needs of the elderly. Given the UK’s ageing population, we hope that this section will not be neglected in future proposals.

21. One area that we feel is under-developed in Healthy Lives, Healthy People, and which may require a greater degree of central intervention than appears to be anticipated, is the importance of public education. The primary care workforce will assist with health promotion and encourage self-care, but there will be a vital need, if this is to be successful and have a meaningful effect on health outcomes and the future health economy, for health education in schools and elsewhere that will be dependent on central government support.

22. We have doubts about the proposals to work with industry through such mechanisms as the Public Health Responsibility Deal, and are concerned that industry lobbying is likely to weaken evidence-based proposals that might otherwise be supported by health professionals. The College recently commented on the Tobacco Control Plan for England:

"The RCGP welcomes the Government’s announcement of Healthy Lives, Healthy People: A Tobacco Control Plan for England published today which sets out how recommends ‘That the Government... ensure[s] that funding for the Royal College of General Practitioners’ surveillance service is extended’"
tobacco control will be delivered over the next five years: the College called for a targeted education campaign to increase the number of smoke-free homes by 2015 as part of our manifesto in 2010.

However we question why so many concessions are being made to retailers and ask why there is such a long lead-in time for shops to remove displays of tobacco.”

**Consultation question b:** What are the best opportunities to develop and enhance the availability, accessibility and utility of public health information and intelligence?

The College is committed to the implementation of evidence-based policy. It is essential, especially given the current restricted financial situation, that those public health initiatives that can be shown to be most effective are resourced, and that the use of evidence is intrinsic to the outcomes framework, the quality premium and the new public health QOF indicators.

There are clearly many opportunities for utilising public health information for public education – it is important for this not to patronise or mislead. Respondents cite the public education over MMR, where arguably the use of generalisations increased public mistrust, as an example of how not to do this.

**Consultation question c:** How can Public Health England address current gaps such as using the insights of behavioural science, tackling wider determinants of health, achieving cost effectiveness and tackling inequalities?

As above, Public Health England (PHE) should test proposals and establish the evidence base before widespread implementation, to ensure maximum efficacy and value for money. What is clear, especially following the arguments of the Marmot Review, is that PHE will need to exert influence well beyond the health service, in other government departments, industry and other public bodies, if it is to maximise success in tackling health inequalities.

**Consultation question d:** What can wider partners nationally and locally contribute to improving the use of evidence in public health?

As discussed earlier, the RCGP Research and Surveillance Centre makes an enormous contribution to the public health evidence base, and it is vital that this work be continued and developed.
We have also discussed at length the importance of cooperation with GP Commissioning Consortia and the NHS Commissioning Board for the effective implementation of evidence-based public health policy.

**Consultation question e:** We would welcome views on Dr Gabriel Scally’s report. If we were to pursue voluntary registration, which organisation would be best suited to provide a system of voluntary regulation for public health specialists?

We think this is an issue for which the views of the Faculty of Public Health should be considered.

23. We gratefully acknowledge the contributions of College members, including members of the College’s Council, our Patient Partnership Group and Health Inequalities Standing Group in formulating this response.

Yours sincerely

Professor Amanda Howe

Honorary Secretary of Council