Faculty of Public Health (FPH) Response to the NHS 2024 Consultation

Question 1. What does the Organisation want to see included in the 10-Year Health Plan and why?

This is the response from the perspective of the professional public health work that is delivered within the NHS and the parts of the system that relate to the health and care system in the UK. It is the guided by the Faculty's vision for the optimal health of the UK population which must also address serious inequalities in health outcomes.

1. For population health delivered in a health and care setting, the importance of a system approach is critical. That comprises an integrated approach within healthcare between community, primary care, hospital and social care settings, linked closely with their commissioners; and between the health organisations and their partners in the wider system that determines health, crucially local government where a large proportion of our workforce now operate. For those within the NHS particularly in England, the whole system within the NHS is fractured into its isolated components. And the links with the wider system are highly variable and – from a provider perspective – largely invisible. There are undoubted lessons from the other countries of the UK where a more coherent approach has been retained or developed, and learning the benefits of integration will be valuable for the whole of the UK.

2. Provision needs to be made – at training and qualified level – to recruit and return components of the professional public health workforce to the NHS in the UK, particularly in England where there has been a serious diminution. The Health and Social Care Act of 2013 compromised what was a stressed public health workforce further. Public health workforces were removed from the NHS and placed in what became, in some cases, isolated settings vulnerable to cost saving. This has had two consequences. First, the influence of qualified and skilled public health professionals disappeared from many NHS settings, including providers and crucially, commissioners whose responsibility is the to health of the wider population. Relationships also

disappeared. Secondly, the public health workforce became less visible in its fractured state and the recruitment of trainees in public health has been seriously compromised. This became more acute as austerity continued, so that while other specialities in health care increased in the years since 2010, public health numbers diminished. The NHS now depends on a small number of advisers, scattered randomly and dependent on where internal champions fund posts, in the context of an ageing workforce. The NHS health focus nationally in England has been diminished with the abolition of the national public health service (Public Health England) without consideration of any consequences, during the 2020 pandemic.

3. Much is made of the importance of other government departments supporting a health agenda. It is not clear within the NHS who is held to account at any level – with consequences- for population health, prevention or even the cooperation inherent in the policy statements concerning the need for a coherent approach to health. The NHS across the UK needs to be more accountable for health outcomes and not merely process measures of operation. Accountabilities, responsibilities and consequences for (non)delivery of a health – and not just health care - agenda within the NHS need to be much clearer. This should include clear actions for which there is a good evidence base, to support reduction of inequalities via the NHS, including reduction of hazards from infections within healthcare settings. For this a development programmes for leadership for health along the lines of the Messenger Report on general leadership in the NHS is required. This will bring a wider perspective on the need for partnerships that augment health service outcomes.

4. A national conversation is required about the importance of a good death. This is a worthwhile public health outcome for those in the population who are at the end of their life, and as currently inaudible, it is both a moral and operational hazard for those working in health services.

Question 2. What does your organisation see as the biggest challenges and enablers to move more care from hospitals to communities?

1. Without doubt the general public do not know where to turn for their health and care needs in a very fractured system. This results in making way to the two locations traditionally understood – hospital emergency departments and general practices, even when current alternatives are available. This is particularly acute in the mental health system for children and adults and in meeting the needs of homeless persons who are ill. There are successful routes that people now understand for instance vaccination via local pharmacies; the provision for homeless people in London via the charitable sector during the COVID-19 pandemic; and the interventions of the current NHS first responders. However other alternatives are opaque.

2. The NHS is lacking a widely understood segmented strategy for addressing current population healthcare needs. This is something in the past that public health professionals would have supported. It is not operationally evident from current commissioners and the Long-Term Plan is too high level to solve contact with the demands of the population.

3. In future, new models, informed by diagnostic grouped usage and clinical evidence of potential alternative provision are required. Based on this evidence alternative models can be promoted to gain the trust of people to use them. One test of this is 24-hour availability where this is clinically appropriate; another is that staff are confident in signposting, and patient records can be located quickly to enable safe and appropriate interventions.

4. It will be important that any shift to community is supported by robust sustainable and sufficient investment to build and support the community NGO and voluntary sector infrastructure, and capacity required for success. The past decade has seen as significant contraction in available local government and NHS funding for VCS organisations which limits the ability for care by and within community partners, and the effectiveness of social prescribing programmes. Innovative models for more sustainable community funding and support is critical for culturally competent, holistic, and person-centred care that our VCS partners are especially proficient at.

Question 3. What does your organisation see as the biggest challenges and enablers to making better use of technology in health and care?

1. Faculty members have direct experience of implementing major and complex new technology in health care, at national and local levels. Most of the problems arise from underestimation of the scale of NHS use, and perhaps consequently changing specifications; too short timescales to expect benefits (which may be overstated or poorly thought through); and crucially the need for substantial training resources – which transcend the 'launch' and may continue for many months afterwards. Companies that pitch for these developments often do not have internal NHS knowledge and those assigned from within the NHS have insufficient time to devote. Addressing these consistent learnings in advance would be advisable.

2. Record linkage between institutions and between primary and secondary is much needed but difficult. Pilot schemes may be helpful – an incremental and learning approach to implementing technology via a clear and stable specification may be a better approach.

3. The NHS app has been well received and should be promoted more to the population as a solution maker. Its expansion into general life and lifestyle may help in delivering messages as to where people can go for which services and preventive health purposes.

4. Consider how people can hold – and own- their own comprehensive health records.

5. We need to continually assess how new technologies are accessed, taken up and utilised by difference communities and with what effect. Digital inclusion and equity are critical for success in especially diverse communities. Engaging communities in all phases of the development, testing, implementation and evaluation of new technologies must be prioritised.

6. For public trust in new technology within the NHS, national publication of the Caldicott Principles which have guardians in every organisation, may be helpful.

7. Integrated personal and population preventive approaches via new technologies will bring a more coherent set of messages to members of the public who may struggle to internalise concepts like ‘healthy life expectancy’.

Question 4. What does your organisation see as the biggest challenges and enablers to spotting illnesses earlier and tackling the causes of ill health?

1. Faculty members have worked on a review of prevention within healthcare settings in the UK and how current leaders, professionals and interest groups in healthcare view optimal progress on prevention in healthcare settings. There is a mismatch in that current NHS approaches focus almost solely on individual programmes of work, whereas those in our review consider that a system approach is crucial particularly in reducing the complex factors that lead to inequalities in health outcomes.

2. Although a systems approach is seen as a high priority, the Faculty stresses that taking every opportunity in healthcare settings to help people reduce their individual risk factors is also very important in reducing poor outcomes. These disproportionately affect those already experiencing disadvantage. These factors include tobacco, alcohol, other substance misuse, lack of exercise and over consumption of poor-quality food. Cardiovascular and respiratory disease and cancers influenced by the above risk factors still account for the largest gap in health outcomes and poor healthy life expectancy, and the gap is widening.

3. Staff in healthcare settings need the training to have confidence in making every contact count from national to local leadership. Currently Faculty members are in contact with clinical champions at every level however these champions become more isolated as delivery becomes local. Consequently, a national signal that prevention is integral to all health care delivery is urgently required.

4. However, there is progress in changing the thinking and delivery in certain parts of the UK. In 2020, Public Health Scotland was established, which is an NHS board with prevention and early intervention at the heart of its vision. In 2023, the Association of Directors of Public Health published

recommendations for how the NHS should deliver prevention in England. In 2024, work is being undertaken by Public Health Wales to produce a 'Prevention-Based Health and Care Framework', which will advocate for the key components needed to embed prevention in the NHS. The FPH's own vision for the UK is presented in its 'Vision for the Public's Health', in which prevention is a central theme within its four priorities and fifty evidence based recommendations.

5. Finally, key to spotting illness earlier and promoting earlier intervention requires investment in health literacy across the life course, health campaigns to educate and inspire members of the public about their health, and a systematic approach to tackling the barriers to accessing and taking advantage of high-quality care. These barriers may include a range of factors including communities' trust, confidence, language, transportation, and ability to navigate the health system effectively. We need to have ongoing and lifelong conversations about health and the health service with the public – it is not the nanny state, it is educating and mobilising the public to be more activated and engaged in creating and sustaining their own health.

Question 5. What can be implemented in various timescales:

1. **Quick**:
    - Learning the lessons from the COVID-19 Inquiry and the systems that worked well which could be scaled for peacetime.
    - A focus on health outcomes in health care to match operational imperatives.
    - Promoting well evidenced 'best buys' in prevention and funding them with consequences for delivery.
    - Build on the NHS app for a wider set of functions in relation to the NHS.
    - Target preventive funding to addressing the best start in life for the poorest children.

2. **Medium term**:
    - Focus on ageing in good health: change the narrative about older years and what healthy life expectancy means.
    - Instigate and fund a leadership programme for health outcomes within the NHS.
    - Re-build the public health workforce within the NHS.
    - Develop a clinical strategy for the NHS that addresses which populations require clinically safe alternatives to hospital, develop the models of delivery and promote to the population.
    - Concurrently consider the implications of this for record linkage, including personally held records.