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IN IT FOR THE LONG HAUL

THE CHALLENGE FOR PUBLIC HEALTH

REPORT

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Institute for Public Policy Research

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Lloydspharmacy
Healthcare for life

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ABOUT LLOYDSPHARMACY

Lloydspharmacy is an innovative community pharmacy and healthcare provider with over 1,650 pharmacies across the UK, mainly in community and health centre locations. The company employs around 17,000 staff and dispenses over 156 million prescription items every year.

As a champion of prevention, management and treatment, Lloydspharmacy was the first national community pharmacy chain to put private consultation rooms in its pharmacies - currently available in 97% of its branches. Keeping people well is a key focus of Lloydspharmacy's healthcare business. It also recognises that the future of primary care must be to deliver high quality outcomes for chronic conditions, such as diabetes and hypertension, and to support local communities in making informed health decisions.

Lloydspharmacy is a key partner of the NHS, and works closely with local healthcare providers to develop and deliver commissioned services to address specific health needs within communities.

IDEAS to
CHANGE BRITAIN

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FOREWORD

RONAN BRETT, HEAD OF PROFESSIONAL AND EXTERNAL RELATIONS, LLOYDSPHARMACY

Lloydspharmacy is working in partnership with IPPR to widen the public health debate and to bring together the views and opinions of key stakeholders to help shape future policy in the public health arena.

Community pharmacy provides a unique, experienced and established network for the provision of health information, advice and support to tackle the most prevalent public health issues – including the significant challenges of 'lifestyle' diseases and the increasing demands on healthcare – in an accessible and non-medicalised way.

As more and more is asked of primary care, the opportunity presented by community pharmacy is clear, especially as we have the most frequent touch-points with members of the public over any other health professional.

Initiatives such as Healthy Living Pharmacies, piloted in Portsmouth and planned for trial across the country, reinforce the real difference pharmacy can make to the health and wellbeing of local communities, by delivering a range of outcome focused, high-quality public health services ranging from smoking cessation and weight management to contraception and sexual health advice.

Importantly, not only can pharmacy, working with other stakeholders such as directors of public health, play a major role in delivering health outcomes, we can also support local government as it navigates its way through the changes that lie ahead. We have been working with the NHS since its inception, and we have a long track-record of understanding and delivering on patients' needs with a range of cost efficient services.

1. INTRODUCTION

With local government assuming responsibility for public health and the wider health landscape set to change significantly as a result of the Health and Social Care Bill, public health is at a crossroads. In one direction lies the promise of greater integration and coordination. In the other is the risk of further 'professional isolation' of senior professionals and slow erosion of public health budgets. This report explores the key opportunities and challenges facing public health in this new landscape.

The decision to devolve primary responsibility for public health to local government represents a significant shift in the way in which public health is configured and services are delivered locally. Local authorities are being charged with bringing together partners and coordinating action across the field of public health. Integration is a key driver for the current changes and its realisation will arguably be the biggest challenge over the coming decade.

These fundamental changes provide an excellent opportunity to rethink our approach to the three key domains of public health – health improvement, improving services and health protection[1] – and to develop a strategic focus on improving access to health and improving health outcomes.[2]

This report draws on a senior-level roundtable discussion on the future of public health held on 28 June 2011 and organised by IPPR in partnership with Lloydspharmacy. Stephen Dorrell MP, chair of the Commons health select committee, kindly set the scene for this discussion by outlining his thoughts on the future delivery of public health, and contributors included directors of public health, senior academics, Whitehall officials and leading figures from a range of professional bodies, third sector organisations and thinktanks.

This report also reflects significant developments in the ongoing public health debate that have occurred since the initial roundtable, including the Department of Health's response (DoH 2011) to its consultation on the public health white paper, *Healthy Lives, Healthy People*.

The report begins by setting out seven key opportunities presented by the ongoing changes to the public health landscape. These opportunities are then explored in greater detail and, where relevant, a series of policy recommendations is outlined. These are intended to help shape current and future policy debates, local service configuration and practice. Our overarching goal is to influence longer-term thinking on public health issues.

1 See http://www.fph.org.uk/what_is_public_health

2 At a national level, Public Health England is charged with bringing together the work that is currently undertaken by a number of organisations and with ensuring coordination across the three key domains.

2. PUBLIC HEALTH: NEW OPPORTUNITIES

The major changes which are currently taking place in public health represent a 'massive opportunity to do something different'.[3] We have a potentially unique chance to change the way in which public health is perceived, talked about, configured and delivered.

There are seven specific opportunities presented by the current changing public health landscape.

1. **To empower individuals and communities to drive the public health agenda locally** (chapter 3):
   We must place individuals at the centre of efforts to improve public health. This should involve empowering people to make informed health choices and to work with a range of health professionals to jointly design and deliver effective interventions.
2. **To take public health out into community settings in order to more effectively target delivery of public health initiatives** (chapter 4):
   We must take public health out into the community and provide information and services in places which are accessible and approachable.
3. **To learn from and promote what works** (chapter 5):
   We must adapt, test and ultimately scale up existing effective interventions so that they positively impact upon the lives of a greater proportion of the population.
4. **To strengthen accountability in public health** (chapter 6):
   The move to local authority ownership offers an opportunity to improve accountability across all aspects of public health.
5. **To balance local and national priorities** (chapter 7):
   The establishment of new national and local structures provides an opportunity to achieve an appropriate balance between the demand for greater localism and the need for national oversight.
6. **To build genuinely broad-based local public health partnerships** (chapter 8):
   Public health must not be the preserve of a single organisation or sector, but instead be built upon genuine collaboration and integration.
7. **To secure a long-term political consensus on public health** (chapter 9):
   The long-term nature of public health work is not aided by the short-term focus of politicians and the limitations placed upon them by electoral cycles.

This report explores each of these opportunities in turn. Where appropriate, relevant recommendations are outlined, which it is anticipated will aid the future development of both policy and practice.

3 The discussion was conducted in accordance with the Chatham House rule and therefore the contributions of the senior professionals involved are non-attributable.

3. PUTTING INDIVIDUALS AND COMMUNITIES AT THE CENTRE

It is important that if we are to achieve fundamental changes in individual behaviour and ensure real progress in reducing health inequalities, we must fully utilise the skills and expertise of individuals and local communities. This will require action at a number of different levels.

First, we need to change the way that we talk about public health in order to increase its relevance to people's lives. We need to develop a public health lexicon that captures the importance of public health and thus does not deter people at the earliest possible stage. As the participants in our roundtable underlined, this will require a greater emphasis on wellness and wellbeing, and less on ill health. Our language should ensure that public health information is more accessible and more likely to encourage behaviour change.

Second, we must place a greater emphasis on involving patients in decision-making and the so-called 'co-production' of health services. This means enabling individuals to work with health professionals to make informed choices about their own health. Such approaches will be most important in enabling individuals to effectively manage chronic and long-term conditions. In order for this to work, the 'public must see the value of working with health professionals to share in the design and delivery of public health initiatives'.

Third, in developing people-centred approaches it is important that we constantly maintain a focus on health inequalities. Local authorities and their partners should begin by mapping local health inequalities in order to ensure that the resulting activities are properly targeted and address the most entrenched problems. The core focus should be on those individuals and communities in the most deprived areas, many of whom do not routinely access mainstream health services.

Finally, we must harness the knowledge and skills of individuals who are well-placed to influence and change the behaviour of others within their local communities in relation to alcohol, drugs, obesity and sexual health. Peer influence has a longstanding place in public health theory and practice. Social network theory has particularly underlined the role of key individuals can play in shaping the behaviour of others within their networks (Thompson 2009). This means local authorities need to understand the networks and relationships that exist in local communities and it requires direct public involvement – detailed and long-term – in the design and delivery of public health initiatives and services.

A practical example is provided by the Department of Work and Pensions and Department of Health's 'Responsibility Deal', which aims to work with small and medium enterprises to deliver a programme on health in the workplace. This seeks to promote and encourage behavioural change on issues such as obesity and cardio-vascular and lung health, using peer affirmation and support to encourage people who might not otherwise access important health information and checks. The departments involved argue that this initiative has improved take-up and access to traditionally 'difficult to reach groups', including young men.[4] The potential reach of workplace initiatives is huge, providing access to key audiences.

Initiatives which encourage individuals and trained public health professionals to work together will have a greater likelihood of changing behaviour, with public health professionals bringing their extensive experience of a range of conditions and interventions and local people offering a greater understanding of what is likely to work for their peers.

4 It should be noted that this material is not based on a detailed evaluation of individual projects and is not intended as an endorsement of the named projects. Rather, it is intended to offer an indication of the different ways in which organisations are approaching public health.

Recommendation: Local authorities should map existing health needs and local community networks and use these as the basis for the effective involvement of individuals and communities in the design, development and delivery of public health interventions.

4. TAKING PUBLIC HEALTH OUT INTO COMMUNITY SETTINGS

The current changes offer an opportunity to adopt more creative and effective approaches to public health. We can leave behind traditional thinking and stop perpetuating the notion that health is something which is delivered by doctors in surgeries and hospital consulting rooms – instead 'public health should be about keeping people out of the medical system. It is not about getting them in.'

The emphasis should be on developing interventions which utilise a range of settings based in local communities and open to all. This means non-traditional thinking about the most effective ways to deliver information, advice and public health services, building on what the available evidence tells us works in reaching key groups and communities.

There must be a widespread recognition that health interventions can take place in an array of settings and that everyone – including doctors, nurses, teachers, pharmacists, employers and parents – has a role to play in addressing the key public health challenges that we face. Our shared ambition must be to facilitate 'access to health, not appointments'. This will undoubtedly require a fundamental shift in the mindset of a range of practitioners and administrators, and indeed the public.

In many instances, this will involve expanding the role of services that currently oversee public health interventions. For example, pharmacies can be found in almost every community in the country, are often the first point of contact for local people seeking health advice, and have contact with individuals four times more frequently than other health professionals (Hampshire and Isle of Wight LPC 2010). Community pharmacies benefit from the presence of highly trained health professionals in a service that is both community-based and more immediately accessible than other, more medicalised services (RPS/RCGP 2011). In this regard, consideration should also be given to bringing a wider range of NHS services into the community – 96 per cent of the population can, for example, get to a pharmacy within 20 minutes.[5] Recognising pharmacies' potential as an untapped resource, the Department of Health has recently established a forum to look at the potential for expanding the role that pharmacies play in improving public health.

Similarly, the London Borough of Camden has rolled out a public health programme that delivers services in 'community hubs', including health screening in high street locations. Its services are funded by local partners but delivered 'outside the NHS branding' in relaxed, non-medicalised settings by trained staff who can facilitate access to other local health services. Camden argues that such approaches have enabled it to achieve a 25 per cent reduction in the gap between male life expectancy nationally and locally (NHS Camden 2009).[6]

Recommendation: Local authorities and other organisations responsible for commissioning should use the widest possible range of community settings to deliver public health services.

5 See http://www.primarycaretoday.co.uk/pharmacy/?pid=4216&lsid=4421&edname=29333.htm&ped=29333

6 See note 3

5. PROMOTING AND BUILDING UPON WHAT WORKS

Public health is a cumulative science. We should constantly adjust approaches based on learning from earlier initiatives and projects. We must draw on and adapt learning from local and national projects in order to identify their relevance for national policy, other localities and other aspects of public health.

The way in which we approach public health has changed significantly over recent decades. In crude terms, we have moved beyond the model of mass media public health campaigns which prevailed for much of the late-20th century. In its place, we have embraced a model by which we focus on particular communities or target groups, empower individuals to make small (and big) changes to their behaviour, and take health out of traditional medical settings into environments that people use regularly and in which they feel comfortable.

It is important in the new era of public health that we identify what is working and which interventions are most effective. These should then be tested out in other areas and, where appropriate, rolled out more widely. It is important that we share effective practice and help other professionals and communities to avoid unnecessary mistakes.

A practical example is provided by the Healthy Living Pharmacy initiative in Portsmouth, through which community-based local pharmacies provide access to trained health advisors who can support local people to access reliable information interventions (NHS Portsmouth 2009). Building on this initiative, the Department of Health has announced that an additional 20 areas across the country have been selected to become Healthy Living Pharmacy pathfinders (PSNC 2011).

Recommendation: Public Health England should work with public health professionals, local government and other relevant stakeholders to collate and disseminate effective practice examples.

In order to identify and promote what works, it is important that we develop an appropriate and realistic approach to performance measurement, one which uses performance measures appropriately. The emphasis should be on outcomes rather than processes: for example, pharmacists are currently 'rewarded' for the number of prescriptions that they process, rather than the number and effectiveness of the public health interventions they undertake. In developing effective performance measures, the emphasis must always be on maximising local flexibility, improving outcomes and encouraging innovation. As a result, all delivery contracts should be incentivised to encourage effective public health interventions. The Department of Health has indicated its willingness to look at incentivising activities which improve outcomes with respect to GP commissioning (Pulse 2011).

Recommendation: The Department of Health and Department of Communities and Local Government should continue to incentivise effective interventions, emphasise the need for local innovation, and avoid unnecessarily top-down approaches to performance management.

Effective evaluation can help to demonstrate both the impact of public health initiatives and the effectiveness of particular interventions in order to identify 'what works'. This would further insulate public health from funding retrenchment and ensure a continued focus on the three key domains of public health.

Recommendation: Public Health England should work with partner organisations to develop appropriate evaluation approaches.

6. STRENGTHENING ACCOUNTABILITY IN PUBLIC HEALTH

The decision to move responsibility for public health to the local level is a popular one. It is seen as breaking public health out of its narrow NHS base in order to ensure that it is visible in the responses of a whole range of public services.

The government has sought 'to entrench public health in local government, in order to increase its reach and accountability'.

The Department of Health (DoH 2010a) has made clear the government's ambition in this area:

> **'People's health and wellbeing will be at the heart of everything local councils do. It's nonsense to think that health can be tackled on its own. Directors of Public Health will be able to champion local cooperation so that health issues are considered alongside housing, transport, and education.'**

The shift from health to local authorities should increase accountability, with the role of elected members being crucial. Existing governance structures, and particularly the work of overview and scrutiny committees, will enable local authorities to hold service deliverers to account.

In order to ensure change happens, it is important that proper accountability mechanisms are built into all relevant public health structures. The government's Public Health Outcomes Framework provides an overarching set of national objectives and has been positively received.[7]

However, what is currently missing is a clear accountability structure, whereby failure to implement the framework leads to remedial action. It is important that we avoid a top-down approach that limits local flexibility. Health and Wellbeing Boards and local overview and scrutiny committees will have core roles to play in monitoring local performance; however, it is not clear what will happen if local authorities fail to prioritise public health or take appropriate actions. We need to maximise accountability of practitioners and decision-makers to local communities.

Recommendation: The Department of Health should require the development of robust local accountability structures for all relevant aspects of public health decision-making and delivery, clarifying what role local health scrutiny and Health and Wellbeing Boards should play in holding directors of public health to account.

The shared ambition of both the government and a range of professionals is an integrated approach to public health. Within local government, directors of public health have an opportunity to influence senior colleagues with responsibility for housing, social care, education, children's services, adult social care, economic development and planning, as well the wider work of local partner organisations. This will ensure that a public health focus is built into all relevant organisational strategies, approaches and budgetary discussions. This can be best achieved from having a seat 'at the top table', among the organisation's corporate directors. The Department of Health has helpfully made clear that this is its expectation (DoH 2011).

Recommendation: In line with its recent commitment, the Department of Health should monitor the positioning of directors of public health.

7 See DoH 2010b, 2010c

We must also ensure that directors of public health are sufficiently skilled to hold their own 'at the top table'. This will require a consistent, national approach to their recruitment and selection.

Recommendation: The Department of Health should ensure that the model job description that is set out in the public health white paper is as a national standard.

Finally, we must ensure that the move leads to increased public health budgets, as directors of public health draw on a proportion of other departmental budgets. Public health budgets must not be allowed to subsidise other areas of spending at a time of considerable public sector cuts (Dowler and Ford 2011). As the Department of Health (2010d) has warned:

> **'Too often in the past, public health budgets have been raided by the NHS to tackle deficits. Not anymore. The money will be ring fenced to be used as it should be – for preventing ill health.'**

If the Department of Health has determined that it wishes to ring-fence this particular budget, then it should monitor budget usage and staff numbers.

Recommendation: The Department of Health should ensure that appropriate systems are in place to monitor public health budgets and staff numbers.

Directors of public health must have the authority, capacity and resources to push the agenda forward across all three domains of public health. The right post-holder; supported by a committed local authority and tight partnerships, will provide a sound basis from which to tackle entrenched health inequalities.

7. BALANCING LOCALISM AND NATIONAL OVERSIGHT

THE ROLE OF PUBLIC HEALTH ENGLAND

In light of the ongoing changes, there has been considerable debate about structural changes and the need to achieve a balance between national direction and local decision-making. This most acutely plays out in the relationship between Public Health England and individual directors of public health. The primary tension relates to balancing the desire for genuine localism with appropriate levels of national oversight and accountability.

It is clear that in public health there are major issues which are common to many localities. Therefore, it is important that Public Health England adopts a strategic role in order to avoid any potential duplication of efforts or wasting of resources. For example, based on the National Outcomes Framework, Public Health England could set out the most important public health challenges and commission national research and develop national guidance. These would then be made available to directors of public health who would, based on analysis of local data and evidence, use those which were relevant to their localities. This would help avoid unnecessary duplication and inform local delivery, while allowing individual localities to determine their own priorities.

Recommendation: Public Health England should identify the biggest public health challenges and work with all relevant partners to develop national guidance.

Similarly, Public Health England should provide advice and ensure consistency regarding the involvement of local health partners, such as third sector providers, pharmacies, schools, businesses and leisure providers. This would help ensure that we achieve the widest possible basis for effective interventions.

The challenge for Public Health England is to establish its own identity as an organisation while not stifling independence and innovation at the local level. Its role should be to 'support and advise, but not tell organisations what to do' – that is, its role should be strategic, providing support to locally based teams, facilitating professional networks and helping to disseminate learning from effective practice.

We must strike the correct balance between allowing directors of public health the freedom to make the right decisions for their localities and ensuring that there is an appropriate emphasis on public health across all parts of the country. The risk is that local authorities will cry foul if they are simply charged with implementing centrally determined priorities.

Recommendation: To aid integration, Public Health England should develop and promote networks of directors of public health.

8. DEVELOPING GENUINE PUBLIC HEALTH PARTNERSHIPS

The local integration of public health activity must be underpinned by a firm commitment to genuine broad-based partnership working. The core driver to move ownership to local government was central government's desire to break out of a primary focus on the NHS. This reflects the reality that public health interventions are routinely delivered by a range of actors, in a variety of settings.

Local public health partnerships should include local authorities, NHS partners and a diverse range of providers such as third sector organisations, pharmacies, schools, colleges and grass-roots community organisations. These broad coalitions must work together to identify the key challenges within their locality and the most effective solutions, coherent strategies, and innovative interventions, and also ensure that the resources needed to deliver real change are available.

This should mean genuine public involvement, cross-sectoral working and the implementation of diverse approaches, such as those set out elsewhere in this report. This means the involvement of a range of local partners in the development and ownership of public health strategies. In particular, it is important that the make-up of Health and Wellbeing Boards includes local health providers, such as general practitioners, pharmacists, dentists and optometrists, whose expertise on delivering effective interventions will be invaluable.

A narrow, non-partnership approach which excludes particular sectors or types of organisation will not result in integration being at the heart of public health organisation and delivery. Consequently, the twin starting point must be a commitment to collaboration and the establishment of a clear, shared, local vision.

Recommendation: Public Health England should develop guidance which emphasises the importance of broad-based local partnerships to support the development of local strategies.

9. BUILDING A PUBLIC HEALTH CONSENSUS
WE ARE ALL IN THIS TOGETHER (FOR THE LONG HAUL)

Most new governments share a desire to differentiate their approach from that of previous administrations. In public health, this has variously been demonstrated by structural reorganisations, changes to key language and the jettisoning of key approaches and 'flagship' initiatives. It is suggested that such changes can often unnecessarily deflect public health professionals from the real task.

Changes of governments invariably lead to major changes in the 'organisational furniture' of public health. This often results in successful projects being sidelined and other major changes which impact upon local delivery:

> **'The baby too often gets thrown out with the bath water – as governments change, words become unmentionable and whole initiatives are ditched as a result of their dubious "political parentage".'**

The ongoing challenge for public health is to demonstrate its own value in order to secure future funding. The long-term nature of public health interventions means that it is difficult to demonstrate progress within the limited timeframes that are expected of other areas of public service delivery. However, without a strong business case and clear evidence of impact there is a risk that public health, amid political and organisational pressures, will come under increasing scrutiny and that budgets and staffing will be threatened. This challenge is particularly acute during a period of economic austerity. As public authorities seek to save money and reduce expenditure, the emphasis on public health may be reduced and relevant budgets diverted.

It is suggested that the very nature of parliamentary democracy in the UK may itself undermine the drive to improve public health outcomes. The electoral cycle:

> **'…makes things very difficult for politicians. They need actions which impact within five years – the timeframe for public health is much longer and does not lend itself to patience.'**

The need to demonstrate progress potentially discourages politicians from taking decisions which will come to fruition in the longer term. While there may be a limited number of 'quick wins', the reality is that public health is a long-term project. It is not about delivery simply in the short term, but rather about putting in place longer term goals and measurement systems.

The only way to genuinely overcome such problems is to develop a cross-party approach to public health.

Recommendation: All main political parties should commit to the development of a long-term vision and strategic approach to public health.

10. CONCLUSION

It is clear that we have an opportunity to rethink the way in which we organise and deliver public health both nationally and locally. Changes to national policy, the shift to local government, a changing public health infrastructure and a range of innovative approaches present a unique opportunity for public health.

This report has identified seven specific opportunities afforded by this series of changes to public health and the wider health landscape, relating to the role of the individual and communities, innovation, developing effective approaches, accountability, partnership working, balancing local and national considerations, and the potential to depoliticise public health.

In order to fully take advantage of these and related opportunities, we must ensure that public health is rooted in local communities. We propose a number of recommendations which will help place public health on a firm footing, with effective approaches to performance monitoring and evaluation.

Recommendations

1. Local authorities should map existing health needs and local community communities and networks as the basis for the effective involvement of individuals, local communities and relevant networks in the design, development and delivery of public health interventions.
2. Local authorities and other organisations responsible for commissioning should use the widest possible range of community settings to delivery public health services.
3. Public Health England should work with public health professionals, local government and other relevant stakeholders to collate and disseminate effective practice examples.
4. The Department of Health and Department of Communities and Local Government should continue to incentivise effective interventions, emphasise the need for local innovation, and avoid unnecessarily top-down approaches to performance measurement.
5. Public Health England should develop appropriate evaluation approaches.
6. In line with its recent commitment, the Department of Health should monitor the positioning of directors of public health.
7. The Department of Health should ensure that the model job description for directors of public health that is set out in the public health white paper is adopted as a national standard.
8. The Department of Health should ensure that appropriate systems are in place to monitor public health budgets and staff numbers.
9. Public Health England should identify the biggest public health challenges and work with all relevant partners to develop national guidance.
10. To aid integration, Public Health England should develop and promote networks of directors of public health.
11. All main political parties should come together to develop a long-term vision and approach to public health.

Most importantly, we must ensure that public health professionals have the space they need to affect real, long-term change. This must begin by ensuring that public health receives 'adequate air time' as part of the ongoing discussion and deliberations about wider health service reform, but also that we seize the opportunities afforded by current changes to ensure that we 'do something different'. If we can realise each of these individual goals, then the future for public health will be a positive one in which we address long-term health inequalities.

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APPENDIX

ATTENDANCE LIST, ROUNDTABLE, 28 JUNE 2011

1. Rt Hon Stephen Dorrell MP (speaker)
2. Alastair McLellan, HSJ (chair)
3. Ronan Brett, Lloydspharmacy
4. Max Mueller, Celesio AG
5. Alison Jones, Lloydspharmacy
6. Paul Bate, 10 Downing Street
7. Dame Carol Black, Cross-Government Health, Work and Wellbeing Strategy, Department of Health and Department for Work and Pensions
8. Professor Lindsey Davies, Faculty of Public Health
9. Angela Mawle, UK Public Health Association
10. David Buck, King's Fund
11. Jo Webber, NHS Confederation
12. Nicola Stevenson, NHS Confederation
13. Stephen Ford, Health Service Journal
14. Dr Quentin Sandifer, NHS Camden and London Borough of Camden
15. Alison Phillips, Family Lives
16. Ralph Michell, ACEVO
17. Dr Alisha Davies, Nuffield Trust
18. Dr Sian Davies, Nuffield Trust
19. Holly Rouse, Fishburn Hedges
20. Ayesha Bharmal, Fishburn Hedges
21. Dr Rick Muir, IPPR
22. Dr Phil McCarvill, IPPR