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PUBLIC HEALTH IN THE BALANCE

Getting it right for London

Public health is an important area of responsibility for NHS primary care trusts (PCTs) and local authorities. Recent Government guidelines envisage a remodelled delivery system as new primary care structures are fully implemented in April 2002. What do managers, specialists and practitioners see as the key challenges? What needs to be done to plan and organise a sustainable, effective public health function on the ground?

In London, public health workers face huge inequalities in health, high rates of communicable diseases, and fragmented planning structures. But the capital also has a wealth of public health experience and expertise. Work is already underway to develop a pan-London public health vision, led by NHS, local government and voluntary sector players.

This research summary, based on interviews with stakeholders in London and nationally, plus a review of recent policies and commentaries, analyses the public health issues faced by local strategists and managers, and offers recommendations to support the development of the function locally. Above all, it demonstrates the need to embrace the complexity and breadth of public health practice, and forge effective local partnerships.

Working in London can feel like a thankless, endless task, but we have real opportunities as a result of the London Health Commission, the leadership being shown by the NHS and the potential of the London Health Observatory. These are exciting times for public health.

Health promotion manager

Public health seeks to improve the population's health through measures aimed at large groups, and complement clinical medicine's treatment of individuals by working to maximise the health of communities.

Effective public health practice depends on co-ordinated planning across a wide range of technical, medical and social disciplines. Those working in the field have a long-established tradition of responding to and managing the threats to community health posed by communicable and non-communicable diseases. They have developed expertise in tackling the broader determinants of health,¹ including housing and regeneration initiatives,² and work to promote the health of disadvantaged communities. Recent international events have underlined their critical role in planning for emergencies.

The re-organisation of primary care within the NHS will bring fundamental changes in how public health is delivered. Measures announced in *Shifting the Balance of Power within the NHS* (see panel below) envisage a situation in which PCTs will be the main delivery vehicle for public health locally, working with new, managed public health networks operating across strategic health authority areas.

TYPES OF PUBLIC HEALTH NETWORKS

Managed networks Locally managed and co-ordinated functions made up of specialists and practitioners across agencies that formally work together to deliver public health.

Local networks More informal groups of people working locally to co-operate in the light of local public health improvement agendas, but with no formal accountability.



The new public health delivery system

Shifting the Balance of Power within the NHS points to the importance of strong frameworks to bring together disparate public health functions at local, regional and national levels. Local agencies will work at community level, while strategic health authorities will co-ordinate and manage performance, and ensure public health objectives are represented in health service planning. Key features include:

- A public health team in each PCT, with a board-level appointment to lead work to improve health, reduce inequalities, and integrate public health in primary care, working with local councils and other local agencies.
- A Director of Public Health in each strategic health authority, supported by a small, high-level team, to performance manage local public health functions and oversee networks.
- A managed public health network within strategic health authority areas, to ensure that PCTs can access specialist functions where it is not economical to provide them separately.
- A regional public health group, co-located in regional offices of Government and led by a Regional Director of Public Health. This will focus on strategies to tackle the wider determinants of public health; regional work on economic regeneration, employment and transport; emergency and disaster planning and management; health-protection functions; and performance management.

Taken from *Shifting the Balance of Power within the NHS – Securing Delivery*. London: Department of Health, 2002.

Managers, specialists and practitioners have broadly welcomed *Shifting the Balance of Power*. But clarity about accountability, responsibilities and how decisions should be made is lacking. Difficulties in defining, locating and quantifying public health at community level must now be tackled.

There is an urgent need to support London's capacity to plan its public health function strategically, and ensure it is underpinned by adequate staffing and shared expertise

In London, the maintenance of public health standards is a matter for urgent consideration. Public health is only one of many competing responsibilities for London's 30 PCTs – and to date, they and their partners have had little opportunity to work out in detail how they will organise public health locally under new structures. While strong planning models are emerging, the capital also faces significant health inequalities and risks.

In particular, there is an urgent need to support London's capacity to plan its public health function strategically, and ensure it is underpinned by adequate staffing and shared expertise. A historic lack of pan-London workforce planning across sectors means that public health staffing levels are not well correlated with local needs. Strong human resource planning and management, within a framework of clear objectives and shared responsibilities, is critical if London's public health workforce is to meet the health needs of local populations.

All these aspects require strong, decisive leadership. Comprehensive training programmes are needed for future public health leaders, practitioners and managers. Organisations must learn to retain what they already know, formally evaluate what they are doing and take that learning forward.

Partnership working, nationally and in London, will also be critical. PCTs will need to work closely with local authorities to manage public health issues, tackle the underlying determinants of ill health (such as housing, environment and education), and act as full partners in regeneration activities.

Background

This research (conducted Nov 2001–Feb 2002) draws heavily on a review of recent public health policy. This was supplemented by one-to-one interviews to gather the views and opinions of 25 stakeholders across sectors, including the NHS, local government, voluntary agencies, academics and independent bodies.

Key issues for London

Geographical, economic and social characteristics make London susceptible to epidemics. Conditions that were virtually eliminated in the UK, such as TB, have now risen to significant levels in parts of London.³ Notification rates in Newham reached 123 per 100,000 population in 2000.⁴ Rates for all sexually transmitted infections are rising and the number of new cases of HIV was at its highest ever in 2000. Increased mobility and international travel has increased the likelihood of identifying cases of communicable diseases that were, until recently, rarely found in the UK.

Co-ordinating the establishment of some 30 PCTs in the capital presents major challenges, and public health is only one of their many competing responsibilities

London's inequalities disproportionately affect economically disadvantaged people. Life expectancy and infant mortality are worse in deprived inner London areas than outer London boroughs, and in manual than non-manual labour groups. Men in the highest social class can still expect to live seven years longer than those in the lowest social class. A baby boy born in Hackney, Lambeth or Newham, is more than twice as likely to die in the first year of life one born in Bexley. Babies born to Asian and Caribbean mothers in London are more likely to die within their first year than babies born in other population groups, and to be stillborn or born with a low birth-weight.

London faces significant civil emergency and contingency risks. London's political and financial significance has put it at particular risk of chemical, biological, nuclear or radiological attack. Since 11 September 2001, a new emphasis on 'expecting the unthinkable' has brought new demands for emergency planners across sectors. Difficult value decisions must be made about whether to target investment at preparing for relatively unlikely but potentially high-impact attacks, or supporting lower-profile health-improvement activities.

London has a complex and fragmented bureaucracy. Large numbers of voluntary sector organisations, health bodies, local authorities and other statutory agencies make pan-London partnership work difficult. Co-ordinating the establishment of some 30 PCTs in the capital presents major challenges, and public health is only one of their many competing responsibilities.

Public health workforce planning in London presents real challenges. The complexity of the function, which includes highly specialised medical functions and broad-ranging community development roles, is compounded by several other factors. These include the disparate nature of the workforce, spread between local government and the NHS; lack of consistent job descriptions and job titles for staff contributing to public health goals; and lack of clarity about the appropriate size and scope of local public health workforces.

There is a wealth of public health experience in London. In the face of all these challenges, London has a strong specialist and practitioner basis, world-class academic support and dynamic champions. The multi-sectoral Public Health Network for London (an informal mechanism to exchange good practice and share knowledge), the London Regional Office and the London Health Commission have all helped to support the development of a pan-London approach to public health.

Key findings

THE PUBLIC HEALTH WORKFORCE

- A wide range of managers in the NHS and local government, teachers, local business leaders and the voluntary sector can all play a part in making a difference to local health and well-being.
- A smaller number of hands-on public health practitioners and professionals (including local authority environmental health officers and health visitors), public-sector researchers and information professionals are central to public health delivery.
- A still smaller group of public health specialists, working at a strategic level or senior management level, or at a senior level of scientific expertise, play a key role in shaping policy and delivery.

Taken from the *Report of Emerging Findings: Chief Medical Officer's project to strengthen the public health function in England*. London: Department of Health, 1998.



Environmental health officers are central to public health work. Housing and education are also key, and every authority has emergency planning staff, skilled in civil contingencies.

Environmental health officer

Health visitors have a lot to offer. We should work with their knowledge and see them as essential to the modern public health workforce, not simply as helpers to others. We should allow them to practise where, when and with whom they can make an impact – that's the real art of public health.

Senior community practitioner

The wider picture

Public health specialists and practitioners broadly welcome new Government guidelines. These set out clear new structures for the planning and delivery of public health, and recognise the role of public health in tackling the wider determinants of health (traditionally a low priority for the NHS). They emphasise the importance of strong public health expertise at every level of the NHS.

It is difficult to locate and quantify the newly structured public health function. While some public health practitioners will have responsibilities directly indicated in their titles or job descriptions, others will not be recognised as public health staff, even though they have a direct impact on community health. The categorisations developed by the Chief Medical Officer may provide a useful starting point to map the public health workforce. Work is underway to analyse the skills and training needs of these groups, and the national debate is gaining momentum.

The devolution of public health responsibilities to PCTs is seen as a mixed blessing. It is positive to bring public health expertise nearer to the people it serves. But as the large teams based in health authorities are broken down into smaller PCTs, there is a perceived danger that individuals' specialities might be lost as practitioners take on generic functions.

PCT/local authority partnerships will be central to effective public health work. Local authorities can influence the 'upstream determinants' of ill health through their management of housing, environment, education and regeneration activities; provide practical help (such as clean water and adequate sanitation) in crises; and make a significant contribution to health improvement and protection. A lack of visible 'health champions' in local government has hindered effective PCT/local authority collaboration, as has the fragmentation of different health-related functions across different local authority directorates.

A broad range of staff contribute to public health. Nurses, health visitors and community practitioners have a wealth of under-utilised public health knowledge and expertise, and are actual and potential champions.⁵ Local authorities now have even greater opportunities to champion public health, with new statutory powers to scrutinise local health bodies, coupled with the expertise of officers and members who have supported the function in the past. Staff who work directly with disadvantaged communities play a particularly public health important role.

The picture in London

Work is already well underway to develop a pan-London public health vision.

As part of the London Health Commission, the Director of Public Health for the NHS in London, the Association of London Boroughs, the King's Fund and others have helped produce the first-ever London-wide strategy for tackling the upstream determinants of health.⁶ The Commission has brought together statutory, voluntary and private sector organisations and is in a strong position to give momentum, coherence and leadership to London's public health agenda.

The London Health Observatory will provide crucial intelligence. With a remit to evaluate public health progress by local agencies across London, and act as an early-warning system for future problems, the London Health Observatory's expertise will give vital support to local organisations' assessment of their own performances, and create a strategic overview across the capital.

Work has begun on a strategic approach to London's public health workforce.

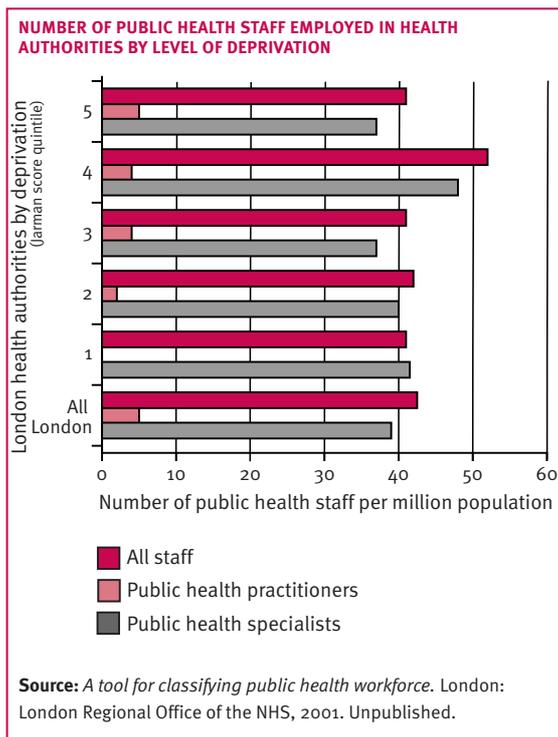
Recent work by the NHS London Regional Office, using a classification tool developed through in-depth discussions with NHS specialists and local authority officers, has started to shed light on the current picture of London's public health workforce. There has been a slight increase in the total size of London's public health workforce (from around 35 per million population in 1996 to around 44 in 2000). But there is no overall correlation between deprivation (or population size) and public health workforce capacity in health authorities, in relation to public health specialists or practitioners.

Devolution of public health responsibilities has been uneven. London's PCTs will have greater responsibilities for delivering public health than the primary care groups (PCGs) they replace, but how they perform might reflect what preceded them. PCGs in areas where the public health function had been devolved for as long as two years have developed effective public health teams. Elsewhere, health authorities have been slower to devolve power, responsibilities and resources.

Staff vacancy rates in London will hamper some PCTs' efforts to deliver public health.

For example, overall health visitor vacancies in London are just above the national average (2.3 per cent against a national average of 1.9 per cent), but some health authority areas face rates up to 9 per cent.⁷ This could have significant implications for working with vulnerable population groups to reduce local health inequalities.

Several organisational models are available for London. In Manchester, the health service and local authority jointly fund public health improvement through a dedicated unit. Another route is to create joint public health specialities between neighbouring PCTs, with one PCT, for example, leading surveillance, while others provide training or regeneration advice, so enabling specialists and practitioners to develop and contribute their expertise while allowing PCT teams to function effectively. Such approaches are already used by PCTs in some areas.



Key recommendations

The public health function

-  **Strong co-ordination of London's public health function will be critical.** The leadership role played by the London Regional Office will need to be taken up by the four new Directors of Public Health in new strategic health authorities, working closely with the Regional Director for Public Health. Key tasks include supporting the development of effective managed public health networks; promoting a pan-London approach to public health working with the London Health Commission; and tackling public health workforce issues with London NHS Workforce Confederations.
-  **Models for robust local public health delivery must be developed.** PCTs will need to work closely with local authorities and strategic health authorities to build local public health networks; identify which tasks they must deliver and which can be met by other local PCTs; and map out workforce requirements against local needs. They will need guidance and advice from their local strategic health authority, the Regional Director for Public Health and local Workforce Confederations.
-  **Detailed responsibilities must be clarified.** The Government has set out broad responsibilities for each constituent tier of the system, but the details will have to be worked through quickly to avoid delay and confusion. It is important that this information is communicated effectively, so that there is broad understanding of how the system fits together at regional and local levels.
-  **Effective public health representation must be developed in all partnerships.** Learning how to speak a common language will enable partners to work together more effectively, identify common goals and take action. All partners, including local authorities, must champion the public health cause and ensure its central place in emergent primary care structures. New, managed public health networks and existing networks must support initiatives linking NHS public health specialists and practitioners and those working in local government and other organisations.

Everybody's talking about local strategic partnerships, but no one seems very clear about what they will do. If they are to focus on complex and intractable social issues, public health's voice is key. We need to get our views heard, build local capacity and make sure we can play as full a role as possible.

Public health researcher

Workforce issues

-  **Local public health workforces should be mapped and capacity assessed.** PCTs and local authorities will need to be sure their workforce is the right size and has the skills mix required to meet specific local health needs. New strategic health authorities will need to ensure that PCTs and their local partners put in place systems to monitor and evaluate impacts of local public health activities against public health and health improvement targets, and are able to pinpoint mismatches and areas of weakness.

We need to make sure that we keep collective knowledge in the system. Otherwise we will forget what we have done and what worked, and face each new situation from scratch.

Local government emergency planner



A common set of public health job titles and core competencies should be agreed. These should cover the spectrum of categories outlined by the Chief Medical Officer, taking full note of current debates. They will be critical to helping the development of local public health workforces and will support workforce monitoring at a pan-London level.



New managed public health networks will play a crucial role in knowledge management. They must make sure that expertise and learning is captured and shared across the broad spectrum of people working in public health. This is particularly important at a time of great change within public health, the NHS and the wider public sector.



A dynamic, outward-looking public health function needs visionary leaders at its helm. Future leaders will come from more broadly based backgrounds than before and will include nurses, environmental health officers and community development specialists, supported by staff with medical expertise. Managed public health networks must support and develop future public health leaders and ensure that public health learns from the past and finds ways of retaining knowledge effectively.



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