The NSMC's response to the *Healthy Lives, Healthy People* consultation

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Introduction

This paper provides The NSMC's formal response to the *Healthy Lives, Healthy People* consultation. We provide an overview of our views in relation to the paper in general, which we broadly welcome. We also highlight significant areas where we believe there is a potential to make further progress. We would be delighted to provide further explanations of our suggestions if required.

Summary

The following are what we believe are the top five issues in implementing the White Paper vision and strategy:

- Greater clarity over responsibility and how the system will be joined up. For example, we have concerns that the current proposals which envisage a direct line of accountability between the DPHs and the CMO will be, in practice, unwieldy and unworkable. Further information on this area needs to be made available to ensure the proposed system is robust and resilient
- Account should be taken of the evidence on effective public health and social marketing initiatives in planning, particularly relating to horizontal and vertical, national and local integration. Examples include successful smoking and teenage pregnancy interventions
- Investment should be rebalanced to focus on prevention. Prevention activity is currently underfunded. The trends towards reductions in staff numbers associated with the structural changes and management costs exercises, and the reduction in the numbers working in the Department of Health, suggest that there may be a capacity challenge for delivery. While we support and applaud the overarching proposal of ring-fencing funds for public health, we would like to see prevention prioritised, and recognition that the workforce plays a key role in achieving these objectives. We also call for the amount of ring-fenced funding to be published
- National social advertising campaigns should be reintroduced as part of the overall mix of methods for achieving beneficial behavioural change, aligned with local priorities. We are concerned that progress made is not being sustained. For example, recent smoking statistics show smokers are not coming forward/accessing services as a result of falls in the levels of social advertising
- Recognition that while some progress has been made, the challenges revealed in the successive Wanless reports remain relevant. Effective behavioural change strategies are needed if we are to achieve the 'fully engaged scenario' he envisaged. We cannot afford to neglect the need to reduce demand on services, or to reduce the disturbing statistics on smoking and obesity prevalence. The statistics on the cost of preventable health conditions to the NHS demonstrate that these areas must continue to be prioritised across the public health delivery system. [see Appendix A]

The NSMC

Established by the Department of Health in England and the National Consumer Council in 2006, The NSMC is a world renowned centre of excellence for social marketing and behaviour change. The NSMC works with a growing list of public sector organisations, nationally and internationally, providing a broad range of strategic analysis, advice, support and training across all levels of the social marketing process. We build capacity within organisations to deliver on their behavioural change objectives.

General comments

The NSMC welcomes the publication of the *Healthy Lives, Healthy People* White Paper. We believe it has the potential to make a significant difference to the health of the population. We were particularly pleased to see the promise to 'reach across and reach out' to address the root causes of poor health and wellbeing, and support the individuals, families and communities who need the most support.

Social marketing is a developing area in the United Kingdom. It has already achieved significant progress in addressing behavioural challenges, supporting public sector and NHS organisations to deliver on, and make progress against, their behaviour change objectives. There is a significant and growing evidence base of the effectiveness and cost-effectiveness of this approach.

Social marketing has a significant contribution to make towards ensuring that the White Paper aims of 'reaching out, reaching across' are achieved. Existing expertise in this area needs to be built into the new public health system. This will be a key factor supporting its success. We would suggest that this could be facilitated by a three tier approach:

- Social marketing and behavioural change expertise needs to be represented on the Commissioning Board
- A Social Marketing Programme Board should be developed, with appropriate representation from the Commissioning Board and the GP consortia
- A new social marketing strategy should be developed

Building on the skills and evidence base developed over the last five years will be essential to realise the agenda. Ensuring that elements integral to a functional, competent system are appropriately supported is a key challenge is the transition from old system to new. To reduce medium-term risk to delivery of the complex and challenging public health agenda, competent support and delivery planning must ensure that public health, and social marketing in particular, are not sidelined in the moves towards establishing robust GP commissioning processes. Public Health England should develop and embed behaviour change and social marketing expertise, working in partnership with The NSMC. These skills should integral to public health practitioner, commissioner and manager career development plans and the Key Skills Framework.

The NSMC would be keen to work with Government to take this challenging agenda forward. We look forward to continuing to support Government in ensuring that its behaviour change interventions are responsive, appropriately resourced, rigorous and resilient.

Responses to specific consultation questions

1. ***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?***

GPs can have a substantial impact on the public health agenda as set out in *Healthy Lives, Healthy People*. There are a number of areas where we believe further progress can be made.

A robust contracting process
The primary influence on GPs will be through the contracts they agree with the NHS Commissioning Board. Delivery of the wider public health agenda needs to be a fundamental part of these contracts if the foundation of public health is to be assured. In particular, there is a need to clarify the scope of GP responsibilities in relation to the health protection and behaviour change agendas.

To incentivise action, we wish to see public health and social marketing outcomes and deliverables explicitly reflected within Quality and Outcomes Framework, the new Public Health Outcomes Framework and within the Payment by Results system.

Communication of sound evidence
GP contracts need to be based on sound evidence which is clearly communicated to GPs. All GP practices, in addition to all the GP consortia, need to have regular contact with the broader public health system. This should ensure they have access to consistent information and national guidance on the operational duties of all agencies involved in the delivery of public health services in England.

Relationship with Director of Public Health
The Director of Public Health (DPH) will be situated within local government. There is a need to clarify the relationship between GP consortia and the DPH, to ensure that the GPs are given appropriate access to DPH advice and that the inter-relationships between the roles are formalised. The proposed accountability relationships are currently unclear and it is doubtful that the Chief Medical Officer would to be able to provide one-to-one support to every DPH, given their direct professional accountability to the CMO.

Specialised support for commissioners as they develop into their new role
There is an assumption that GPs and GP Practices have good understanding of public health and the needs of the populations they are serving. However, the new arrangements will see GPs taking responsibility for commissioning across a geographical population, rather than the registered population with which they are familiar. GPs and Practices will need support to expand their focus beyond diseases and special interests, with help to recognise and address the wider determinants and their commissioning responsibilities in relation to this agenda. Building the capacity to address public health commitments should be a priority for consortia.

GPs will need support to understand the needs of their population − both in gathering data and interpreting it to ensure appropriate services are commissioned. Social marketing has a role in this area, to ensure that GPs and Commissioning Consortia are accessing the right information, particularly in relation to commissioning behavioural change initiatives based on the best available patient/user insight.

Robust monitoring and accountability for commissioning and delivery of public health services

There is also some doubt as to whether GPs themselves will have the capacity to lead the commissioning process, given their busy day jobs. Ensuring that adequate safeguards are built into the new system to ensure that commissioning at the local level supports progress at the national level will be a key challenge. Ensuring that appropriate technical skills and competencies, such as social marketing, are available at the local level to support commissioning of specialised services (such as health protection and behavioural challenges) will need to be considered. There is a need for greater clarity on how the new systems and processes will support and encourage progress in these areas.

Greater clarity is needed on how progress will be monitored, explicitly addressing the need to consider public health outcomes, programmes and development, including workforce development of the human resources within the system required to deliver the programmes.

2. ***Public health evidence: What are the best opportunities to develop and enhance the availability, accessibility and utility of public health information and intelligence?***

There is an apparent confusion or conflation of evidence with information and intelligence. Public health evidence is not just about incidence, prevalence, morbidity and mortality data. There is a need to look more broadly at what constitutes evidence and how this can be used more effectively. This is not necessarily about commissioning more evidence, but about ensuring that the available evidence within a system is used most effectively and efficiently.

While we welcome the PHE responsibility for commissioning NICE, we believe there is a need to consider the scope of the evidence which NICE is developing. In particular, we would suggest that some resources need to be targeted at developing the social marketing evidence base. Since its inception, one of the key functions of The NSMC has been to ensure that commissioning of social marketing activity is based on the best available evidence. It has developed significant expertise in this area, and a suite of resources to support organisations to do this more effectively. Consideration should be given to ensuring this level of expertise is reflected within the commissioning process. One mechanism for achieving this would be through ensuring that board level social marketing expertise is available on the Commissioning Board, and that NICE is tasked, in partnership with The NSMC, to gather evidence on social marketing and behaviour change for use across the public health delivery system.

Availability and use of sound data [information and intelligence] will be a core requirement for an evidence-based public health system. This will be essential to ensure that limited resources within the public health delivery system and public health service are appropriately targeted. The availability of accurate local and national health statistics and behavioural data will be crucial. Local government and GP consortia will require reliable data to make informed decisions on local health priorities.

Improving access, quality and utility of data, and clarifying accountability and data sharing protocols, will be a major piece of work requiring robust standards. Work is required to understand what data is currently available and how it can be integrated at both local and national level. A systematic approach should be put in place to support data integration.

Areas which need to be considered include:

Data quality
Data quality remains a key issue under the new arrangements, where ‘any willing provider’ may provide a service. A fundamental requirement for good and reliable data is good quality entry at source. Data-keeping and quality requirements should form a key part of contracts with service providers. This will need to be monitored effectively. A further challenge that needs to be addressed

is that existing systems are often incompatible and practice information can be difficult to access. With multiple providers this situation could be compounded and greater clarity is needed on how these risks will be mitigated.

Access to data
Ensuring public health professionals located in local authorities have access to practice information, including disease registers, QOF and population data will be essential. The current structures limit access to certain databases to NHS employees through secure NHS systems. This will need to be addressed with guidance to ensure this does not limit activity within the new structures.

Multiple pockets of information
There is a need for greater clarity and coherence of the public health information systems, within the context of the new structures. The old structures were fragmented, with NHS information largely coming through Public Health Observatories, and local government information through local authority intelligence units. At a national level, in addition to government departments, there were a number of other sources and holders of information, such as COI and the Health Protection Agency. There is a need for streamlining of this system, to ensure greater integration, avoid duplication and save money. This is particularly a concern as many of the NHS systems are 'closed' to local authorities.

Areas which could be further developed include effective links within and across the university system, to ensure that consortia have access to academic and evidence-based advice. For example, The NSMC has been actively working with universities on developing a network of universities for social marketing. This function should and could be expanded to include public health more generally.

Technical skills and competences
This area will need to be sufficiently resourced – requirements may currently be underestimated. Enhancing the skills pool and making best use of available skills by pooling resources should be considered.

System focus
There is a need for greater clarity on how the evidence, information and intelligence functions will be delivered across the three domains of public health – health improvement, health protection and health and social care quality. For the DPH, one of the key roles has been to promote and protect the health of the population – delivered through independent advocacy and building on firm evidence. Ensuring this continues to be seen as a credible function, and that public health commissioning is as robust as the commissioning of acute care, etc. will require a system focus on health information, intelligence and evidence.

At present, as many of the most pressing public health challenges are associated with behavioural challenge, public health authorities are unable to provide access to the full range of information which a GP commissioner would require in order to commission effectively. Greater clarity is needed on how some of the more expert and technical aspects of evidence, information and intelligence, such as behavioural insight, will be collected, collated and analysed, and made available across the new public health delivery system.

3. ***Public health evidence: 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?***

Capacity and capability in each of these areas is likely to be scarce and scattered, so grouping to create cohesive units is essential. Effort will need to be focused at a national level to provide support and guidance from a central source. In the medium to long term, local organisations will need to create and enhance this capability locally if they are to effectively address public health.

Targeted action is needed to ensure that Public Health England, consortia and local authorities are supported to develop and deploy robust social marketing competences, skills and capacity. Ensuring this is built into performance development and assessment will be critical. Tools such as the National Occupational Standards for social marketing, developed by The NSMC with Marketing and Sales Standard-Setting Body, should be a key resource.

There is a need to ensure that monitoring and audits of GP consortia focus on commissioning for behaviour change, including the use of best evidence for running public health programmes. Previous work undertaken by The NSMC on cost-effectiveness has demonstrated that in general, insufficient weight is given to what works/is cost effective in commissioning decisions. Developmental activity will need to be taken forward to address this gap.

In terms of health inequalities, the focus should be on finding evidence for interventions and measures that close the inequalities gap, rather than just on collating and analysing data which describes it. The extent to which the new delivery system is capable of translating evidence into policy and practice will be a fundamental measure of its effectiveness.

Since its inception, The NSMC has worked to compile and communicate research knowledge, successful policy modelling and professional experiences to improve health and reduce inequalities. Within a context of limited resources, there is a need to ensure that existing expertise, such as that of The NSMC, is harnessed. This will help ensure that available resources are used consistently to address the current gaps in health outcomes, and that research and policy modelling is translated into practical advice. For example, The NSMC has developed a number of evidence-based resources − such as our Procurement Guide to Social Marketing Services and tool for assessing the cost-effectiveness of behaviour change programmes − to enable local commissioners to effectively commission behavioural change interventions.

4. Public health evidence: What can wider partners nationally and locally contribute to improving the use of evidence in public health?

A key challenge is improving the use of evidence and ensuring that partners across the system understand it. We suggest there are a number of areas where improvement could be made:

Ensuring that information and intelligence is shared across geographical and organisational boundaries appropriately and effectively

We reiterate that the current information and intelligence structures are fragmented. To ensure best practice, consideration should be given to how they can be made more accessible across the health and social care landscape, particularly given the new provider models and interfaces.

At a practical level, examples such as The NSMC's case studies database (ShowCase) provide a good example of how we could support the use of evidence in public health. Publicising best practice, promoting the use of robust methodologies and rewarding best practice is essential to its effective dissemination.

If all partners were encouraged to share evidence – including of what didn't work – both nationally and locally, the embedding of evidence across the system could be facilitated. Practitioners and commissioners could be better supported in accessing and using evidence effectively.

Access to appropriate expertise for robust commissioning
A particular challenge in achieving the public health delivery outcomes will be to ensure that Public Health England and the new Commissioning Board have access to appropriate social marketing advice and expertise. This will help ensure that behavioural sciences and evidence are considered as part of the commissioning and delivery system.

Paralysis by analysis
It is important, however, that the use of evidence does not paralyse practitioners into indecisiveness and inaction, nor impose an excessive burden. Since innovative approaches are to be encouraged, partners should ensure that a lack of direct evidence does not necessarily prevent an informed proposal from going ahead. For example, this could be possible as a thoroughly monitored and evaluated pilot. The NSMC's case study database provides a number of examples of social marketing activity which have been taken forward and had significant results. The level of evidence-gathering undertaken needs to be appropriate to the scale of the activity.

Capacity and capability of system
The delivery system's capacity and capability to compile data, analyse policy and apply this intelligence to public health delivery is not evenly distributed. There are significant gaps in relation to public health expertise, and also to social marketing.
Effectively harnessing the knowledge and skills offered by national and local partners, such as The NSMC, will be essential in order to tackle the inequalities in public health. The university network set up by The NSMC will also be a key partner, able to contribute their own evidence base and experience to inform activity in this area.

Clear articulation of roles and responsibilities
All partners need to understand their roles and responsibilities, and be adequately resourced in order to deliver on them. This is about financial and human resources – in effect it is about the overall strength of the delivery system, and in particular its capacity and capability to deliver. Ensuring that workforce planning, training and development are based on effective situational awareness and strategic objectives will be crucial. Evidence and information needs to be collected, collated, analysed and utilised to inform business planning and strategy development.

Ensuring that national and local activity in support of behavioural change is co-ordinated, cost-effective and effective will be essential. Building capacity to support this should be considered, through measures including:

- A focus on social marketing and behavioural challenges in basic and post-basic training across the NHS and social care landscape
- Promoting access to existing resources, such as The NSMC's resources
- Focusing the Department of Health research programme on intervention research, rather than problem identification and description

Balancing role of industry and role of NHS/social care landscape
There also needs to be an appropriate balance between the role of industry and the role of the NHS and social landscape in supporting evidence based decision making on behavioural change topics. With a plurality of providers in place, ensuring that the analytical and operational capacity is robust will be a key challenge.

5. ***Regulation of public health professionals: 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 broadly endorse the Scally report. However, there are a number of challenges which need to be picked up if a system of voluntary registration is to be imposed. Defining the public health profession has long been a cause of contention. Identifying who should be included within the regulated frameworks would be crucial, as is ensuring that the relevant standards of practice are achieved. Registration itself is not regulation – there is a need to understand the difference between the two activities. The register at its most basic is a list of people who are deemed to be qualified to practice. Regulation is about ensuring the continued quality of that practice. In the case of public health, as a multidisciplinary profession, the key challenge would be ensuring that the regulatory element is consistent with medical regulation, if true equivalence is to be achieved.

In terms of organisations, while we do not have any objection to the RSPH as a lead agent for practitioner regulation and registration, there will be a need to ensure that a robust recognition of the standards of practice across the range of public health occupations is built into the process and system. We suggest that further consideration is needed in the following areas:

- Defined areas of practice, such as social marketing and environmental health, already have explicit standards and frameworks. Consideration should be given as to how to ensure that existing expertise in these areas are considered and reflected within regulatory frameworks and processes
- In the case of social marketing, we believe that health promotion professions should have social marketing competences built into their statutory training, and would recommend working with The NSMC to further develop these standards, building on the relevant National Occupational Standards
- There is a need to understanding what makes a competent public health delivery system. At present, the development of NOS and regulation retains the focus on the competence of individuals. However, achievement of the public health outcomes will require that this focus is broadened to consider the competence of the system as a whole, and of the organisations which constitute it. Ensuring that regulation and registration are tied into workforce development across organisations will be crucial – particularly within the context of a plurality of providers, and no obvious over-arching framework for monitoring workforce planning across the range of providers, other than the proposed skills networks

Appendix A: The cost of preventable health conditions[1]

Table 11.2 Comparison of societal health and cost impacts

Behaviour/Illness	Alcohol misuse	Smoking	Obesity	Other CVD	Mental Illness	Total
Health Impacts						
Premature deaths	18,500	130,000	10,000	17,700	3,100	179,300
Years of life lost	365,000	307,000	70,050	203,600	11,490	957,140
DALY	460,000	528,000	233,000	276,000	709,000	2,206,000
Costs to Individuals and households	£21.6b	£18b	£4.1b	£4.2b	£5.4b	£53.3b
Costs to NHS and public care services	£3.2b	£2.7b	£1.2b	£0.6b	£9.1b	£16.8b
Costs to other public services and (income)	£5.0b (£2.9b)	£1.1b (£9.1b)	£0.1b	£0.1b	£10.2b	£16.5b (£12b)
Costs to employers	£2.6b	£2.0b	£1.5b	£0.7b	£4.2b	£11b
Social impacts/ intangible human values	£16.1b	£16.8b	£7.4b	£8.8b	£34.4b	£83.5b
Total Cost	£45.6b	£31.5b	£14.3b	£14.4b	£63.3b	£169.1b

[1] Evaluating the Societal Costs of Potentially preventable illness: Developing a Common Approach. G. Lister , R. Fordham , D.McVey et al in Future Public Health: Palgrave Macmillan 2009

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