British Medical Association

NHS WHITE PAPER

Public Health support for GP Commissioning

A joint statement from GPC and PHMC

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STANDING UP FOR DOCTORS

BMA

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Introduction

'Health Care Public Health' (HCPH) describes a set of public health skills acquired as part of specialist public health training and practised by members of the public health specialty who are involved with the commissioning of health care services. It is also known by the moniker 'public health commissioning support'.

Core competencies for HCPH include:

- Assessing health needs of populations, and how they can best be met using evidence-based interventions;
- Supporting commissioners in developing evidence based care pathways, service specifications and quality indicators;
- Providing a legitimate context for setting priorities using 'comparative effectiveness' approaches and public engagement.
- These competencies are needed in order to sustain health services within a cash-limited system.

A further role which can fall to HCPH is that of engagement with the public over service development and in particular over the prioritisation of services. HCPH is ideally placed to undertake this function because it relates to populations and not individuals and therefore is free of conflicts of interest in relation to individual patients or treatments. This function is not just about conveying to patients in lay terms the relative benefits of treatments or groups of treatments for particular conditions. Crucially, this function must also deal with the issues of the relative importance of treatment for different conditions or groups of patients within an overall cash-limited system. This role of HCPH as honest broker will be key to protecting the ability of general practitioners and hospital specialists to continue to act and to be seen to act in the best interests of their individual patients.

Government has offered the medical profession the opportunity to take greater control of health services, inviting general medical practitioners to lead the commissioning process. For this approach to succeed and so secure the future of the NHS, the British Medical Association believes that it is essential that the key role of the specialist in Health Care Public Health is clearly understood within the whole of the medical profession and by government, and proper provision made for its place in support of GP commissioning.

Health Care Public Health and GP commissioning

Commissioning aims to ensure that available resources secure the right technologies in the right places to secure as much health improvement and health care as possible within available resources. This occurs within an environment of continual flux in what is required by doctors and patients as health needs change, new technologies and/or evidence of effectiveness become available and the amount of funding fluctuates.

In general medical practice the doctor has the responsibility of mobilising appropriate local health resources in support of the needs of their patients. Consequently, GPs are in a strong position to understand the needs of their own patients. Yet, this view, derived from their own day-to-day practice, is only one aspect of a strategic view. Within the general practice community, even within a locality or community, there will be many GPs, each of whom will have a unique view.

The role of the healthcare public health workforce is to assist general practice commissioners in synthesising their individual view of health needs into a position that can be used to drive commissioning on behalf of their consortia's registered population.

The successful criteria for commissioning include:

1. The ability to command support when making choices about the allocation of resources;
2. Balancing resource allocation decisions across the whole of the healthcare portfolio for both existing and new services;
3. Minimise unnecessary health care interventions and use of poor value interventions;
4. Setting out specifications and standards for services that will achieve the clinical, quality and productivity outcomes sought and securing these through the contracting process;
5. Monitoring services to ensure delivery of these outcomes;
6. Developing and improving the care pathway for patients to better achieve desired outcomes.

Underpinning these are the transactional aspects of commissioning. So having decided 'what we need' and 'how much we need' and 'with what resource' and 'to what standard' there are elements of commissioning concerned with the contracting and procurement that govern the 'from whom', 'at what cost', and 'how to measure the results'? The contracting and procurement aspects of the commissioning cycle need to be undertaken in consultation with commissioners and public health specialists but not directly by those groups.

The delivery of successful commissioning is a team undertaking. This team includes information scientists, experts in systems change, public engagement and communications specialists and project managers as well as HCPH. This paper though focuses on the contribution of HCPH that can:

1. Summarise the evidence setting out the relative value of different interventions;
2. Set out the contribution that interventions make to defined outcomes and the relative return of investment across portfolio of commissioned services;
3. Identify areas for disinvestments;
4. Design monitoring and evaluation frameworks, collect and interpret results;
5. Support the development of care pathways to improve patient outcomes.

Effective GP Commissioning by active GPs

General Practitioner commissioners acting on behalf of their colleagues and peers and the patients registered to a consortia will also remain providers of primary care. It is inevitable that from time to time dilemmas will arise between the GP as provider of care and the GP as commissioner of care. A mechanism is required to deal with these dilemmas. We propose that the incorporation within commissioning process of public health specialists operating in the field of health care public health provides the route to resolve these issues.

HCPH specialists operate as 'population doctors' whose work is founded on explicit utilitarian principles: the greatest good for the greatest number. HCPH specialists operate by using information to examine the health needs of a population and develop diagnostic hypotheses, undertaking relevant investigations which seek to test these hypotheses and then formulating appropriate responses based on expert knowledge drawn from a range of sources, including that of local experts in primary and secondary care. They offer independence and objectivity with regard to individual cases, because they work at population level.

HCPH specialist workforce is an essential ingredient in securing excellence in GP commissioning. This workforce has undergone specialist training and plays a critical role in the specifying and sourcing of data and the analysis and interpretation of that data to create intelligence to inform commissioning. Data without interpretation remains statistics. Health care commissioning based exclusively on data will always be passive. Health care commissioning based on expertly crafted intelligence will lead to active commissioning, able to define, to pursue and to achieve sought after objectives.

Alongside the Public Health specialist workforce there is a need to imbue public health skills in two other key groups. For general practitioner commissioners there is a need to provide a set of public health skills that enables this group to understand the benefits and limitations of a population approach. While developing this skill set would enable GP commissioners to undertake some public health tasks themselves more importantly it would also furnish such commissioners with an ability to understand when it was appropriate to make referrals of issues to public health specialists and to frame issues in public health terms. It would also enable GP commissioners to critically assess the quality of product provided by public health specialists and facilitate shared ownership of emerging decisions informed by PH input.

For secondary and tertiary specialists, usually employed as consultants in hospital specialties, there is scope for the re-emergence of the clinical epidemiologist. This group comprises specialist clinicians who in addition to their primary specialty are also trained in specialist aspects of public health medicine. Equipping a group with such skills enables them to contribute a specialist clinical perspective informed by a population approach and is essential in developing whole systems of care that span all healthcare sectors.

Public Health should not all go to Local Authorities

The Public Health workforce in England is about to relocate to homes in the national public health service and in Local Authorities. Government is clear that Public Health is about improving health outcomes and that much of this work has to focus on tackling the wider determinants of health and it has also mapped out a process to migrate the Health Protection Agency into the proposed national Public Health Service. This strategy has much to commend it, yet it endangers the HCPH function that has developed within the local NHS environment since 1974.

There is a compelling argument that Health Care Public Health needs to be retained within the NHS, as part of the commissioning function of the reformed NHS. We believe that GP consortia need to have ready access to HCPH, along with other skilled support staff. At present there are about 250 Public Health physicians across England. This dedicated specialist workforce is augmented by a larger number of public health specialists currently working in commissioning organisations and who incorporate elements of health care public health within jobs that also include health protection and health improvement roles. There is a need to employ this workforce in a manner that preserves its utility and provides cohesion and continuity. We do not believe that Local Authorities will see the support of health care commissioning by GP consortia as part of local authority business and accordingly we would counsel that the health care public health workforce requires an alternative home that secures its expertise within the NHS family.

Employment of the HCPH specialist workforce could be secured within the NHS in a number of ways. These include:

- Transfer of those currently working in Specialised Commissioning into the National Commissioning Board;
- Transfer of health care public health specialists into the national public health service and contracting services back to commissioning consortia;
- Transfer of HCPH physicians into the larger GP consortia;
- Transfer of HCPH physicians into host GP consortia, to work across a sub-national area;
- Transfer of HCPH into a host local authority to contract services back to commissioning consortia
- Transfer of HCPH physicians into universities on honorary NHS contracts, with rolling contracts for provision of GP commissioning support.

HCPH will best be organised to deliver a critical mass of expertise that provides resilience in the face of organisational evolution; that offers an ability to cope with a wide range of demands and to avoid duplication of work in relation to appraising evidence for clinical services and models of care; and yet is situated sufficiently locally to develop the working relationships needed to be a trusted source of both informal and formally commissioned advice. In practice this will mean locating HCPH at a level larger than local authority (to obtain critical mass) but more local than current regional structures to relate effectively to consortia and local authorities and to enable responsiveness to local demands. This could be incorporated into the proposed national Public Health Service thus preserving all three domains of public health within that service. However, alternative models are also feasible although not favoured by the specialist workforce.
Our clear preference would be for options which maximise the co-location of specialists in all three domains of public health. This is important to ensure the critical mass of specialist

workforce and to maximise the co-operation across all three domains of public health in optimising population health.

It is currently envisaged that Specialist Public Health trainees will be placed within the national public health service and seconded to other public health settings in order to obtain experience and develop competences the required for specialist practice. Of necessity this will require trainess to work across Local Authority, NHS and university environments. The career option for doctors wishing to work to improve health services would remain, with the continuation of the role of the Public Health Physician.

Summary

1. Health Care Public Health specialists have competencies that will be essential for successful GP commissioning;

2. GP commissioners need to be seen to be making objective decisions while continuing to work as GPs and this requires the population perspective;

3. Public health specialists are in a position to engage with the public over issues of service design and prioritisation as 'honest brokers';

4. GP commissioners need to retain direct access to the medical Public Health workforce, and other elements of the HCPH workforce: this specialist workforce should not be lost to the NHS by being placed in Local Authorities. Alternative models of provision of HCPH are desirable.

5. The development and practice of Public Health skills by general practitioners and hospital specialists (and others involved in the development of health care) is an important facet to the successful delivery of clinician-led commissioning.

British Medical Association, BMA House, Tavistock Square, London, WC1H 9JP
www.bma.org.uk