Submission to the Health Select Committee Inquiry into Public Health

From the Yorkshire and Humber Health Trainer Hub Team

Summary

- The transfer of health improvement into Local Authorities is positive in principle but we have a number of concerns about what the transfer will mean in practice for health trainer services and for health improvement provision more generally.
- The fragmentation of both commissioning and provision across a number of agencies poses dangers in terms of lack of health improvement (and specifically health trainer) expertise being available where it is needed.
- There is a real danger than funding for health improvement will be reduced to what is left after Public Health England and health protection has been funded.
- Health trainers and community health champions have the potential to enable organisations to engage more effectively with communities, both as lay people themselves and through their reach out to other members of the public.
- Health trainers now have a strong evidence base and the potential to save a lot of public sector money if programmes are effectively commissioned and scaled up.
- For health trainers (and other practitioner level public health staff) there is a lack of consistency around training and continual professional development and an absence of clear career pathways that needs addressing.
- The effectiveness of health trainers (and community health champions and social prescribing) depends on there being community based activities to improve health which they can signpost people to. Many of such activities (both in voluntary and statutory sectors) are being cut which in the long term will increase ill health, health inequalities and demands on health care.
- Health trainers are part of a wide range of health improvement activities which engage lay people in their delivery and which are achieving results but which need more recognition, support and mainstreaming if we are to develop a health and social care system which enables people to achieve not just great life expectancy, but greater healthy life expectancy.

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1. The Health Trainer Programme has been developed over the last five years in a unique collaboration between the National Team at the Department of Health, regional teams and local services. An enormous amount has been learnt about how to recruit, train and support a lay workforce to effect behaviour change in some of the country's poorest communities. This submission is being made by the Yorkshire and Humber Health Trainer Hub Team which is responsible for rolling out the Health Trainer Programme across the region.
2. We welcome the transfer of health improvement functions to local authorities. Health trainers are the only public health workforce specifically focussed on addressing health inequalities. They are about promoting health and engaging with disadvantaged communities to do this – an approach that sits well with local authorities. However we have a number of concerns about what the transfer will mean for health trainer services and for health improvement provision more generally.
3. The remit of public health and of DPHs is huge and we are concerned that the focus of activity tends to be on health protection, health care delivery and information gathering/analysis rather than on commissioning/delivering health improvement and addressing inequalities in disadvantaged populations and we are concerned about a potential loss of focus on health improvement for the reasons we set out below.
4. There was some real fragmentation of health improvement services following the commissioner/provider split in PCTs and more recently the running down of PCTs ahead of reorganisation. Many, including health trainer services, previously managed in public health directorates, have gone into providers in other NHS bodies, the voluntary sector or local authorities or have become social enterprises. Whilst in some instances this is working well, overall there has been a reduction in the involvement of senior public health managers with understanding of health improvement in commissioning and running programmes. This process is being exacerbated by ongoing management reductions and reorganisation.
5. The fragmented nature of services and the continual churn in commissioners and managers means that the lessons learnt from rolling out innovative programmes like health trainers are in danger of being lost. It is commonplace for health improvement services to be commissioned and managed at higher levels in statutory organisations by people with no understanding of these services.
6. We welcome the principles behind Health and Well Being Boards and endorse the need for a more strategic approach to health improvement, but are concerned that they could just become talking shops which make little difference on the ground, and that it will be difficult for them to implement a strategic approach when services are increasingly fragmented in different provider organisations. We are concerned that sufficient attention must be paid to building relationships and shared understanding between members of health and well being boards in order to be effective.
7. Where commissioners are interested in health trainers we have concerns about where they will get the information from to commission effectively. The National Health Trainer Team at DH which has steered the roll out of the programme has gone as has the National Support Unit for Health Inequalities which supported the implementation of health trainers in spearhead districts. Some regional health trainer teams have now gone, others have stretched their funding to continue until March 2012, after that it is unclear where the knowledge and learning accrued over the last few years will go, although various possibilities are being investigated.
8. We have reservations about ring fencing public health monies as health trainers are already involved in areas like leisure services and social care and if they are just seen as a service to

be commissioned through public health we think that could limit their potential to work across many departments within local authorities. We also have concerns about the amount of funding that will be left for health improvement once money has been allocated to set up Public Health England and for health protection.

9. In Yorkshire and the Humber there is a very varied picture re the level of funding for health trainers (and for health improvement services generally) and it seems uncertain whether they will be commissioned through local authorities or GP commissioners in the future, or possibly both, in the future. Many health trainers work closely with GP practices, and some are based in them, but many also work in community settings with some of the most disadvantaged groups. There is a danger of GP consortia just seeing commissioning health improvement as the local authority's role and the local authority not having the resource or expertise to do this effectively. With tightening finances the danger is that commissioners see health improvement as someone else's responsibility and health trainers could fall between them.
10. As currently described we think that health premiums would be unworkable and will exclude some local authorities which do not meet the criteria through no fault of their own, whilst penalising others who might for example get worse because of population movements rather than anything to do with the local authorities activities. Incentivising health improvement is complex and the health premium needs to be carefully designed so that it does not have the effect of disproportionately rewarding improvement in those populations which are easier to reach and change, rather than those that are harder to reach and slowest to change.
11. Health trainers are lay people, drawn from the communities they serve and therefore have a lot of knowledge of those communities. Their expertise, along with that of other non clinical staff in the public sector could be an important aspect of public involvement in commissioning which is currently undeveloped. Many public sector staff are low paid, live in the areas they work in and are members of 'the public' who so far, the public sector has been very poor at engaging with.
12. In principle we agree with having outcomes, but think they need to be carefully framed so as not to create perverse incentives. So for example they need to encourage evidenced based interventions which specifically address the inequalities gap or there is a real danger than health improvement programmes will be designed to 'get the numbers in' but will increase the gap. Health trainers are one such evidence based intervention.
13. Health inequalities outcomes are more likely to be addressed if some indicators reflect different levels of attainment i.e. using a physical activity example, an indicator could be about encouraging people to moving on from where they are now to an improved position for example a positive behaviour change from being sedentary (inactive) to being more active (i.e. moving from being active on zero days per week to one day per week, one to two etc) in order to capture changes in those with the lowest levels of inactivity.
14. Although there are separate Outcome Frameworks for the NHS, public health and for social care, it is positive that, where outcomes depend on integration and alignment, indicators are replicated across the three frameworks, or complementary indicators are included. However we feel there is more scope for integration and that to ensure all sectors work in partnership to achieve outcomes, it is important that there are shared reporting arrangements and that all parties benefit from incentives.
15. In relation to workforce, attention within public health has been focussed on the regulation and development of senior staff, mostly at consultant and DPH level. We think that there should be a shift of focus towards the needs of the public health workforce at lower levels, like health trainers, but also other health improvement practitioners, some of whom have lost their jobs as funding has been scaled back. At the moment there is a lack of consistency

around training and continual professional development and an absence of clear career pathways that needs addressing.

16. There are many promising developments in relation to lay engagement in public health, in particular the community health champion role has achieved greater recognition in recent months (one of the Big Society Awards went to the Altogether Better Programme in Yorkshire and Humber which is training and developing champions). Health Trainer Services are increasing recruiting and training health trainer champions who are volunteers from target communities who promote the service and signpost people into it, thereby extending the service's reach into marginalised communities. There needs to be much greater recognition of the role volunteers are playing in promoting health, particularly in some of our most disadvantaged communities, and investment in developing and supporting this form of lay engagement.
17. We support the findings of the Marmot review and have concerns, some of which we have detailed above, that the social determinants of health and health inequalities are not being addressed by current policy, and indeed are getting worse, one example being in relation to housing policy.
18. Health trainers have an important role to play in addressing inequalities, but, despite what is now a strong evidence base, including clear evidence of how they can save money in the short and medium term, programmes have not been scaled up to a level where they can make a real difference to population outcomes.
19. Social prescribing is another approach, which can be combined with health trainers to achieve excellent results for people who are socially isolated or have low level mental health problems, which has not been scaled up.
20. Health trainers and champions are increasingly supporting people living with long term conditions through simple measures like for example helping diabetics to develop new meal plans, shop for appropriate foods and manage on a budget. Both this approach and social prescribing, if scaled up across health economies, could save considerable amounts of money and reduce health inequalities.
21. Health trainers, community health champions and social prescribing all depend on there being community based activities to improve health which they can signpost people to. Many of these activities are run by voluntary and community groups and are disappearing as these groups experience cuts in their funding. Walking groups, cook and eat sessions and weight management support are just some examples of activities that do not need a lot of funding but do need some, and which are vital if those in marginalised groups are going to be able to change their behaviour to improve their health.
22. In conclusion, health trainers are part of a wide range of health improvement activities which engage lay people in their delivery and which are achieving results but which need more recognition, support and mainstreaming if we are to develop a health and social care system which enables people to achieve not just great life expectancy, but greater healthy life expectancy.

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June 10th 2011