



PUBLIC HEALTH AND PRIMARY CARE

A discussion document and draft policy statement by
Doctors in Unite

First issued January 2019
Revised May 2020

Table of Contents

Introduction.....	2
Summary.....	3-5
DIU’s Vision for Public Health.....	5-7
DIU’s Vision General Practice	7-9
Personal Contact and Continuity of Care	7
The Primary Care Team.....	7-8
Clinical Planning	9
Social Prescribing	9
DIU’s Vision for a decentralised NHS.....	9-10
The Emerging Concept of Neighbourhood	10
Towards the Peckham Model.....	11-12
A Public Health Offer to Neighbourhoods	12-14
Healthy Living Centres	13
Screening	13-14
Community Development.....	14
Neighbourhood Public Health Leads	14-15
What Every Clinician Should Do For Prevention	15-16
Advocate For Change.....	15
Guiding Patients Through Their Health Journey	16
Screening	16
Risk Factors	17
The Case For Dual Accreditation	17
Training.....	17
Career Structure in Public Health Nursing.....	17-18
Workforce Planning	18
Interim Arrangements.....	19
Organic Development	19
Costs	19
Pay and Conditions for GPs	20
Pay and Conditions for Public Health Consultants.....	21-23

INTRODUCTION

In January 2019, Doctors in Unite issued proposals relating to public health and primary care. This document has now been revised.

In the light of COVID-19 the authors believe that if these proposals had been implemented before the pandemic struck then the UK would have been able to respond much more quickly to the need and would have been in a much stronger position to plan and deploy local responses.

The government has allocated significant resources into protecting the front line of the NHS at the level of hospital services, with particular investment in the building of Nightingale hospitals. However, it has put almost no additional resources into primary care or community services to deal with COVID-19.

We believe that strengthening primary care and community services as laid out in our paper would mitigate the effects of COVID-19 for five main reasons:

1. Those working in primary care should look after populations and communities as well as individuals and their families. Dual training and accreditation for GPs and nurses in public health and primary care is essential. Neighbourhood public health leads would co-ordinate appropriate local responses to a pandemic, for example, by supporting people at home with COVID-19, isolating them and contact tracing in ethnically and culturally appropriate ways.
2. Primary Care Networks of GP practices should be funded to provide care home and appropriate domiciliary care during the pandemic. Community organisations should be integrated with primary care, which during the COVID-19 lockdown could deliver food, medicines and other essential items as well as provide support for isolation, loneliness and respond to mental health issues.
3. We support a social prescribing model, which in normal times encourages patients to go out, meet people, socialise and stay active; during a pandemic this is necessarily amended, and patients are asked to stay in and not meet people, but to still socialise, keep in touch with others and remain active.
4. We develop the idea of local democracy through Neighbourhood Health Committees which would organise appropriate medical, psychological and social care, led by public health leads working seamlessly with directors of public health who have authority and independence which has been devolved from central control.
5. We propose professionally independent public health advocacy so that the people can trust the advice and information they receive.

SUMMARY

Doctors in Unite (formally the Medical Practitioners Union) has a long record of developing ideas which change primary care in the UK, from the Family Doctors' Charter in the 1960s to Alternatives to Fundholding in the 1990s. Today general practice is again in need of a clear vision for the future. That vision must reflect the need for prevention to tackle the causes of a steadily escalating workload.

UNITE is increasingly emerging as the main union for public health, bringing together public health practitioners (including health visitors in its CPHVA Section) and public health specialists from both the medical and non-medical routes of entry (UNITE is the only medical trade union recognised in English local government).

The NHS at its inception was not just a mechanism for providing health care free at the time of use. It was also a set of mechanisms by which the health of the people was pursued as a social goal. Until 1974 it included the Health Departments of local authorities, which in the first quarter of a century of the NHS cleared the slums, cleaned the air, eradicated polio and diphtheria and so dramatically cut the prevalence of TB that the TB hospitals were closed or reused. We need again to have a set of mechanisms for tackling the social, environmental and commercial determinants of health. This time however they must also do what the NHS has never done – reach into the workplace.

We believe that general practice must cease to be viewed simply as a set of tasks carried out in relentlessly driven isolation. It must return to its role as family practice, committed to understanding local communities and the families that live in them, and supporting them in pursuing their own health. Community development, social prescribing and advocacy on community issues must sit alongside continuity of care – part of a team of professionals treating a community and the people within it. Primary care estate should increasingly combine with other community assets to create hubs which mix primary care health care services with community centres and leisure centres in a process that promotes healthy living and empowers local communities to bring about change in their culture and environment.

Neighbourhoods, typically 20,000 to 50,000 by population, corresponding to natural communities, should be the catchments for these hubs and the organised base for these services. They should also be a unit for public health activity with each neighbourhood having a neighbourhood public health lead. Ideally this should be a half time public health consultant who has a primary care background. Often this half time role could be combined with half time general practice or half time public health nursing.

We believe that neighbourhoods should also be the basic democratic unit of the NHS, with elected Neighbourhood Health Committees composed partly of local people elected by local people, partly of health professionals elected by health professionals and partly of health professionals elected by local people, with a majority elected by local people but also with a majority of health professionals. From this base the NHS

structures would be built up as a People's Industry. Our proposal for neighbourhood public health could be instituted without making this change, but we believe that the two proposals would reinforce each other.

The total cost of our proposal for neighbourhood public health, on top of the NHS, local government and public health spending which would be delegated to it, would be £8-10bn a year of new money. £200m of this would be spent on 2,500 half time public health consultants, there would be 10,000 extra GPs to expand family practice and there would be £6.5bn to fund local community activities.

£8-10bn a year is a huge sum in relation to current public health spending, a large sum in relation to current primary care spending, and a large sum in relation to projected growth in NHS spending, but it is not especially large in comparison with total NHS spending. We believe it will be justified by its impact on NHS demand. It will also have direct benefits for deprived communities including the levelling up of opportunities for local improvement. It may also have benefits for promoting mutually supportive communities and social responsibility. The values of the English village – enterprise, mutuality, compassion, cooperation and locally driven improvement – underpin the proposal.

The coronavirus epidemic has highlighted the importance of public health, of community cooperation, and of a capacity directly to influence social norms and cultures. These are central to this proposal. The success of South Africa in containing the virus in difficult socioeconomic circumstances is probably due to the strength of its local public health infrastructure in communities, a powerful argument for the introduction of the structure we advocate in this paper.

We believe there is a need for training programmes which will train doctors to practice part time in general practice and part time in public health. This would create doctors not only for the neighbourhood public health leads but also for population health management and for healthcare public health. We believe training for such a dual accreditation could take six and a half years.

There are also important implications for career structures in public health nursing, where we believe there should be additional posts in public health specialist training schemes for public health nurses who wish to take on this role.

It will take time to build up the necessary number of dually accredited doctors or other public health specialists from a primary care background. For an extended transitional period, the role will in many neighbourhoods be filled by a GP or other primary care professional with an extended role, who could be supported by consultants in adjoining neighbourhoods. As time passes the proportion of neighbourhoods in which the role is filled by a part-time consultant will increase as some of the extended role practitioners train as specialists and others retire and are replaced by part-time consultants.

Public health should be regarded as part of the NHS but should work across local government and the NHS. It should be able to carry out professionally independent advocacy. Public Health England should be an NHS body instead of (as at present) part of the civil service.

DIU's VISION FOR PUBLIC HEALTH

The NHS is a mechanism whereby the health of the people is pursued as a social goal, not just a way of paying for health care.

Nye Bevan's NHS had three wings – family health services (general practice, pharmacy, dentistry and opticians), the hospitals and the health departments of local authorities. Since a sharp bureaucratic divide now separates the NHS and local government we often forget that part of Bevan's NHS was run by local authorities and focused on prevention.

In its first quarter of a century the NHS cleared the slums, cleaned the air, eradicated polio and diphtheria, and dramatically reduced the incidence of TB, enabling TB hospitals and TB wards to be closed or reused. These achievements of the early NHS show that the NHS did once emphasise prevention.

Since reorganisation in 1974 it has lacked the means to do so. This could have changed in England when public health returned to local government in 2013, but instead the coalition with the Liberal Democrats decided to introduce a distinction between "the comprehensive health service" and the "NHS," which allowed the 2015 Conservative government to cut funds for public health saying health visiting, school nursing, drug and alcohol services and health checks were no longer part of the NHS.

In the devolved nations public health remains integrated, but the need to also link it to local government remains a challenge. How to structure public health is a separate issue not dealt with in detail in this paper, but the principles are that it must work across local government and the NHS, and be included within the concept of a national health service.

The cuts in England were like stripping the lead off the roof to make buckets to catch rain, since failure to prevent disease creates a workload crisis which then overwhelms general practice and hospitals.

Obesity, alcohol-related diseases and diabetes stoke this crisis. So does unhealthy ageing - if healthy life expectancy had kept pace with overall life expectancy, longer lives would actually reduce demand as people live longer before becoming heavy users of the health service. Instead, an inequality emerged in which the poor not only die younger, but also spend longer in illness - a factor neglected in NHS resource allocation formulae.

We need political action to address the environmental and commercial determinants of health. We need healthy housing, green spaces, healthy transport, and good

quality work. Asserting freedom to choose unhealthy lifestyles should not give companies free reign to maximise their profits by persuading people to harm themselves.

Health is improved by resilient communities, mutual support and the assertion of control over the factors that influence health. These political and environmental factors, including community empowerment, are central to the public health agenda.

All health professionals have a role in public health – they can advise how to live healthily and speak out about the factors that make it difficult. Every contact with the health service should be an opportunity for preventative medicine.

Public health doctors, a medical specialty which also has a non-medical route of entry, are health professionals who treat a population, identify the threats to its health and act as agents of change to improve it. These roles need recognition and protection.

Public health nurses play an important part in the health of children and families which is vital to creating healthy communities, in both neighbourhoods and schools.

Environmental health should be recognised as a health profession, and the enforcement of public health laws must again become part of their armament.

A fully comprehensive NHS would also reach into the workplace. It was once thought occupational health might become the fourth wing of the NHS. There was debate at the time the NHS was established as to whether the Factories Inspectorate (now the HSE) should be part of it.

The best (albeit rather old) evidence available shows that about a third of the social class variation in ill health results from factors occurring in the workplace, which is not surprising as people spend that proportion of their adult waking time at work.

Over the last 40 years the proportion of the workforce benefitting from an occupational health service has declined dramatically. In 1979 about two thirds of the workforce had access to such a service. One third had access to a comprehensive service providing clinical support for emergencies and minor conditions, employment rehabilitation and support to help sick and disabled workers remain in work, health promotion, environmental surveillance and biological monitoring.

About a fifth of the workforce were served by an occupational health service carrying out epidemiology and research. Today less than a quarter have access to any service and comprehensive services (as defined in 1979) are rare.

We need a workplace public health service. DIU believes that this should be provided by (or, exceptionally, where a high-quality service already exists, licensed by) a public body. For especially hazardous industries this could be an industry-wide service operated by HSE. For other large workplaces, or for groups of adjacent workplaces like a shopping centre or industrial estate, it could be a dedicated service provided by

an NHS body. For smaller workplaces which are not part of such a grouping, it should be built into the primary care system.

It should be financed by a levy on employers, but it would be jointly controlled by employers, trade unions and local communities, and it would consider the environmental and cultural impact of the workplace on the community as well as on the workforce. It should be viewed as part of the NHS. The health and safety enforcement bodies should be viewed as part of the NHS in the same way that we advocate Public Health England should be.

DIU VISION FOR GENERAL PRACTICE

DIU has led thinking about future organisation of general practice for over a hundred years. We initiated the Family Doctors' Charter in 1966, addressing insufficient funding, falling recruitment, high workload, poor morale and poor prospects. We ran the Alternatives to Fundholding campaign in the 1990s. The Labour government which implementing these proposals dramatically improved general practice.

However, general practice is again in crisis. Clinical commissioning in England has been eroded by commercial procurement, and throughout the UK the concept of population-oriented general practice has been undermined. General practice is now seen simply as a series of tasks. Commercialisation and deskilling directly creates the scope for services like GP at Hand, which cherry pick patients and eliminates face to face contact and the continuity of care.

The late Julian Tudor-Hart, a role model for many young doctors in the 1970's, paved the way for developing the infrastructure of the Family Doctors' Charter. He also introduced a public health ethos into general practice. His work on screening his practice's population was exemplified by his work on blood pressure control. The notion that GPs should look after practice populations as well as individuals is core to developing general practice for the future.

If we go back to what was important in general practice in the period up to the 1990s we will not be reinventing the wheel, but building on core values.

Personal contact and continuity of care

It is a privilege to know a person and their family so well that their medical, psychological and social circumstances are wholly understood by a practitioner. This leads to a continuity of care. We need to rediscover this model. Evidence that the continuity of care affects life expectancy is emerging. Person centred care should move towards family centred care, from the rigidity of allocating six minutes per patient to a consultation matched to a patient's needs. Adequate time with patients coupled with mutual mentorship for practitioners would reduce morale and recruitment issues.

The Primary Care Team

Health practitioners from different backgrounds need to practice with personal contact and continuity of care, but can only do so as part of a functioning team. This team needs to be clinically led, with each professional group having its own autonomous sphere.

It is outdated to think of a single practitioner solely looking after a list of patients now that part time work, job-shares and portfolio careers are widespread. Flexible working helps morale and career progression; however, the patient must perceive seamless, long term, personal, continuous and joined up care delivered by a team.

There is no single model for such a team - each will be different. To deliver personal care they should probably remain relatively small. Large practices may need to divide into smaller teams. Perhaps the old model of hospital consultant firms should be revived. These were mostly made up of doctors at different grades led by a consultant; in primary care this would not be so doctor heavy.

A functioning team that all knew a list of patients might include GPs, nurse practitioners, practice nurses, and mental health / talking therapists. It would also need receptionists, administrative staff, advice workers and interpreters. To address prevention properly it would need health visitors, health trainers and health & wellbeing community development workers. Currently physicians' assistants have utility, but in the longer term they should be replaced by a different model of medical training with more access for those from other health professions.

Reception staff are particularly important in this context. Although the role as gatekeepers for GPs can be misunderstood, good receptionists know the patients and their families and need to become core members of the primary care team.

Better status, pay, conditions and training would enable reception staff to move from their old role of working for the doctor to a more facilitating role working for the patient, signposting people to appropriate services, social prescribing and enabling patients and their families negotiate the health care system. They have a crucial role in resolving some of the problems we currently have with access to GPs and health practitioners.

Health trainers often have other titles, but all work with people with long term conditions including chronic pain, and often facilitate group work. They can link well with clinical and non-clinical staff in the team.

District nurses, health visitors and midwives all need to be drawn back into the wider primary care team. Social workers would also be better placed in these teams, particularly as the integration of health and social care proceeds.

Access to mental health and other expertise should also reside within primary health care teams. Psychologists, family therapists, psychiatrists, community psychiatric nurses, occupational therapists and physiotherapists should all be part of larger

teams. Such skills are necessary for the sake of patients and families, and in building, maintaining and nourishing their primary care teams so they work efficiently.

To all these we would add occupational health workers, housing workers, school nurses, school liaison staff and public health workers.

We want training in community and public health to be offered to all primary care staff so that they can better know their patients and provide continuity of care, and get to know their families and communities. They should direct their knowledge and skills to the communities they serve.

Clinical Planning

Clinical commissioning should not be about GPs leading commercial procurement - it should not be about commercial procurement at all. We should end purchaser/provider separation in England, as it has been ended in the devolved nations, and abandon the word 'commissioning' which has now, contrary to the intentions of its original advocates, become wholly equated with procurement. Our vision is for local communities, supported by their primary care teams, to make decisions about the nature of the support their primary care system needs from the specialist services. They can then plan the services their community needs and provide these directly where they can operate at the population level of the local community, or working together with other communities to benefit larger populations.

Social Prescribing

Patients do not just need health services. They need access to a wide range of social facilities and opportunities for healthy leisure, recreation and community networks. Social prescribing must be central to our approach to good health.

DIU's VISION FOR A DECENTRALISED NHS

In the 1980s we first advocated decentralisation of a primary care led NHS, empowered from the base up. We proposed Neighbourhood Health Committees, covering a health centre catchment. They were partly elected by and from health professionals and other health workers, and partly by and from residents, and partly by residents from health professionals.

Such a committee would be rooted in local communities, with most members being professionals, and the majority being elected by the people. We foreshadowed the current proposals for the People's Industries, nationalised industries managed on a mutualised model.

For elections we envisaged constituencies for groups of health professionals and workers, and for client groups, as well as constituencies at large. Where a parish

council, town council or community council corresponded to the neighbourhood it could appoint some of the representatives.

These committees would manage all health and social care services organisable at that population level, and would have public health powers to address the health of their neighbourhood. For services needing a larger population base, neighbourhoods would work together at district, county and regional level through committees formed half from representatives of the bodies at the lower level, and half composed partly of councillors appointed by the local authority, and partly of members elected directly on the tripartite basis described above.

Money would be allocated to neighbourhoods and then pooled to create the funds for the larger population level, but with inbuilt risk sharing in the pooling approach. When purchaser/provider separation was introduced we advocated locality commissioning as the alternative to fundholding, thinking it could be democratised through the processes we had advocated earlier. We envisaged primary care teams working together with local communities to plan the care the community needed.

In England this concept of clinical commissioning has become lost in the commercial procurement that has been imposed, whilst in the devolved nations the primary case base of decision making has not been developed as fully as it could have been. It is time to revive our concept of neighbourhoods managing local services and pooling resources where necessary. We would however look now to natural communities as the basis for neighbourhoods, rather than health centre catchments, to empower local communities and strengthening their population health role.

THE EMERGING CONCEPT OF NEIGHBOURHOOD

Neighbourhood is now emerging in official thinking in England, especially as a core part of the planning in many STPs. It draws practices together into geographical groupings of 30,000 to 50,000 people to arrange health and social care.

This differs from our concept in several ways:

- It isn't always based on natural communities, and many of these STP neighbourhoods will be larger than we would advocate.
- It does not build in local democracy, either for health workers or for residents.
- It is still tied to the principle of commercial commissioning.
- It devolves responsibility but not power. Power will still be centralised.
- It lacks the important public health element.
- It will lack resources and freedom to use them creatively to meet need.

These elements need to be reintroduced into the concept.

If it is possible to add these back into the structure of neighbourhoods, they could play a key role in reviving primary care and needs-led services. Without them,

neighbourhoods will become the latest device by which central government devolves onto others the blame for its decisions.

TOWARDS THE PECKHAM MODEL

Another emerging parallel theme is that of the healthy living centre, a community centre, health centre and leisure centre, which can serve as a focus for social prescribing and healthy activity. We support the concept of such healthy living centres and foresee one in each of our neighbourhoods, replacing the health centre of our original proposals.

The best model for healthy living centres is the Peckham Experiment of 1935 to 1939, and 1946 to 1950. Its Pioneer Health Centre was the first health centre in the world. It did not deliver health care, but instead asked the question 'what is health?' It answered this with an environment where people in their local neighbourhood could spend their time discovering for themselves what was good for them.

The experiment included annual 'health overhauls' on a family basis, where each member of a family had a thorough health check (possibly the first time health screening had been done) starting from the youngest upwards. The findings were then presented by a doctor in a 'family consultation.'

The positive health of the family, rather than the negative findings of disease, was emphasised (although any pathology was also conveyed). The family were free to decide what to do about the state of their health. Today healthy ageing would be as important a focus as parenting and childhood.

Families could use the facilities of the purpose-built Pioneer Health Centre, where the experiment was housed. This had a swimming pool in the centre, with a long room running its length, a cafeteria with kitchen, a nursery, gymnasium, theatre space, recreation and sports spaces, and plenty of outside play areas for children and adults.

Clinical rooms and a laboratory were situated separately upstairs. The architecture of the building was crucial. It was mostly glass with partitions to create a sense of space and allow people to see what was happening in any part of the building.

The membership was by family, as the experimenters believed that the family, not the individual, was the unit of health. Families had to live within 'pram-pushing' distance of the centre to join. This is perhaps a good definition of what a neighbourhood could be.

Food and nutrition became key factors in the experiment. A variety of nutritional deficiencies were quickly demonstrated. The quality of food in Peckham at the time prompted the experimenters to rent a local farm where fruit and vegetables were grown and fresh milk obtained. It is arguable that the organic food movement developed from these ventures.

Perhaps the most important feature of the Pioneer Health Centre was the non-hierarchical, non-authoritarian approach which emerged. If people were told what to do they generally didn't do it - but if they were left to follow their own health journey then good health became contagious. All people required was the right environment and the correct conditions.

An atmosphere of non-directional self help, non-competitiveness and intergenerational interaction produced families who to this day regard their time at the centre as a major influence in their lives. Non-sectarian open discussion, participation and control by people (i.e. democracy) are the major elements. Illness prevention needs to include empowering the individual patient (including families, carers and guardians) to manage their conditions.

The Pioneer Health Centre closed in 1950 just as the NHS came into being. Its time has now come again, and its principles should be incorporated into the new vision of the NHS and the public health role of primary care.

A well-known current healthy living centre is the Bromley-by-Bow centre, which brings together NHS primary care with a community centre and other services, and has a strong emphasis on social prescribing.

Neither the models used in Bromley-by-Bow or Peckham are a precise reflection of what we advocate. To the social prescribing and service relocation of Bromley-by-Bow, we should add the personal empowerment provided by Peckham. But to Peckham we need to add collective empowerment. It is not enough to change the lives of the participants – it must also change the local community.

Healthy Living Centres can transform health. Every neighbourhood should have one.

A PUBLIC HEALTH OFFER TO NEIGHBOURHOODS

Before 1974 the NHS conducted illness prevention and public health through Local Authorities. It worked. It could do so again.

Public health is already within the remit of councils. Social care, children's services, transport and housing are some of the statutory responsibilities of Local Authorities in England, Scotland and Wales and they are all social determinants of health. The development of Neighbourhood Health Committees should be a statutory responsibility laid on local authorities, supported by their Health and Well Being Boards (an English structure which should be extended to the devolved nations, but restructured to be more democratic and powerful).

Whilst the Director of Public Health would continue to deal with city-wide issues, such as transport, air quality, employment and health inequalities, local decisions around housing, food quality, social care, early years and children's services, social prescribing and community engagement would be devolved to neighbourhood level.

The primary healthcare team would be part of a Neighbourhood Health Committee (NHC) supported by an NHS department of the Local Authority, and would commission services. Skills within the existing Clinical Commissioning Groups would be at the disposal of neighbourhoods. Local housing, environmental issues, availability of good food, social care, dementia care, early years, children's and family services would be commissioned locally. The local voluntary sector would be part of the NHC.

Healthy Living Centres

Leisure centres, libraries, children's centres and care homes, and existing NHS estates like health centres, cottage hospitals, and community clinics should become hubs. LIFT buildings would be taken back into the local state as local authority health premises.

Each healthy living centre would be democratically run and controlled in the style of the Pioneer Health Centre. The user groups, although accountable to the NHC would run their centre as they wanted. Centres should have leisure facilities, a library and information technology available, alongside community kitchens, and cafes with intergenerational meeting spaces (from toddler groups to dementia cafes).

GP surgeries, pharmacies, opticians and dentists should have sufficient space to deliver their services. Healthy living centre waiting areas could include people doing Tai Chi or exercise classes while a toddler group meets by the cafe and people tend raised beds in the courtyard. Patients waiting to see the GP or other health professional may get what they need from a health trainer, advice worker or social prescriber, or whatever group or activity they see going on.

The neighbourhood's public health team would ensure that the centre was outward-looking and focused on community leadership, not just on the provision of services. There is a balance to strike between convenience of catchment size and the comprehensive nature of the centre. A swimming pool would need a bigger population base than a primary care team, a play group, keep fit club or library.

Larger centres would need a bigger population base than 25,000 people. But as the population base expands then issues of access become more relevant - especially for those without private transport, low incomes, families, those with disabilities and older people. Economies of scale must not be allowed to take priority over the communities with which people identify. You cannot provide community leadership to people who have no loyalties to that community.

Screening

Health screening should be done on a family basis. Physical health screening for children is currently evidence based and done by health visitors. We need to promote the positive health of a family and identify factors which may need attention, such as obesity, alcohol and drug use, risks of diabetes and adverse childhood events. Health

trainers would accompany families in their journeys through health and follow up in holistic ways so that they could make any necessary changes.

Dr Julian Tudor Hart would devote Fridays to visiting schools and seeing entire families for an hour each, every two years, to assess the overall development of the children in the context of education, school and family dynamics.

People who do not live in families, such as single-person households, lodgers and temporary house-sharers should not, of course, be excluded by the emphasis on families.

Community development

Supporting people working together is central to a neighbourhood committed to improving the health of the people.

The role of neighbourhoods in public health should also address physical environments. People should work together to shape a greener environment, focused on safe recreation and attractive spaces. Schemes like Incredible Edible in Todmorden use small patches of land to grow healthy food and improve the environment at the same time. We should plant forests of public fruit trees reaching deep into our urban environments. There should be an aim that everybody can see greenery most of the time, and that an opportunity to exercise in natural surroundings is only a short walk away, be that a park or a riverside path.

Community development should build on local community assets. Communities should focus on strengthening mutual support and social networks, a proven major determinant of health.

We must recognise that there are limits on what can be expected immediately. Many people, particularly those in our most disadvantaged communities, are exhausted by the day to day struggle of survival. The aim of community development is to raise people's capacity to work together to change the parameters of that struggle.

Most of the time, on most issues, most people do what they think is normal. Neighbourhoods should focus on creating healthy cultures. Creating this 'new normal' could be a local lunch club offering hot rather than cold food, a local fast food outlet serving healthy food, or reshaping streets to make walking and cycling easier.

NEIGHBOURHOOD PUBLIC HEALTH LEADS

Each neighbourhood needs a public health lead, dedicated to that neighbourhood as its principal public health adviser. This individual would have the same role at a neighbourhood level that the director of public health plays at borough or county level.

They would treat the population, analyse its health needs, identify the measures required to address those needs and to improve health, and act as professional agents of change to bring about those measures.

The public health lead would become one of the professional members of the Neighbourhood Health Committee and be its principal public health adviser. If there are other devolved public structures, such as Area Committees, or parish or community councils, then the appropriate neighbourhood lead(s) would ensure proper public health advice.

An important part of the role of the public health lead would be to ensure the delivery of the public health offer described previously.

The public health lead would also ensure that the services provided by the neighbourhood were needs led, population oriented and outcome focused, with a full grasp of the contribution prevention can make, rather than being directed from a thinking oriented around individual service silos.

Independent advocacy would be a core role of the public health leads who would write their own Annual Public Health Report and would engage with all issues affecting the health of their neighbourhood.

We believe that neighbourhood public health leads should have the full skill set of a consultant in public health. Ultimately all neighbourhood public health leads will be fully accredited public health specialists employed as part-time consultants (or part of the role of a consultant), under the direction of the Director of Public Health. Transitional arrangements will be needed for some time to come as the necessary body of trained individuals builds up.

Not all neighbourhood leads would be doctors. Individuals from the non-medical route of entry to public health might also work in this role and combine it with their own initial professional background as, say, a health visitor, researcher or community development worker. Public health specialists from a public health nursing background, with their roots both in public health and in primary care, might find the role particularly attractive. There will also be those who only wish to work part time, where the role is their sole job in a work/life balance which allows time for family commitments or other forms of activity.

WHAT EVERY CLINICIAN SHOULD DO FOR PREVENTION

Advocate for Change

Prevention is not just about clinical interventions. The concepts we set out are about creating the right conditions for health to bloom. Creating a more equal society would make most difference to improving the chances for children to be healthy and for adults to age healthily.

Health professionals should be encouraged to see the promotion of this kind of change as something they can legitimate and support in their daily life rather than something to be left to those who have a special interest in public health. It is the place of every health professional to be an advocate for health.

Every clinician should understand the general causes of the diseases they treat and be prepared to be an advocate for change.

Social Prescribing

Social prescribing has become a general term for people accessing non-medical ways of helping their problems. However, it started specifically with the clinician using a system embedded in the medical model – that of presenting the patient with a prescription where it was understood by both patient and doctor that it would do them good. Rather than prescribing medicines, a social prescription can mean anything that helps the patient. It has ranged from exercise on prescription to boilers for people in fuel poverty. Social dispensers can support doctors in that role.

Guiding Patients Through Their Health Journey

Health trainers or similar who often work in the community voluntary sector do this very well, accompanying patients in their journey to find out what is available, and more importantly, what they want to do. Clinicians ask patients ‘what is the matter?’ Health trainers ask ‘what matters to you?’

Clinicians should draw on their support and absorb part of that ethos. They should, for example, understand the relationship between health and work so that they can recognise the contributions, positive and negative, that each is making to the other.

Developing a long-term relationship gives the best opportunity to talk about prevention, so general practitioners will be well placed to play that role if they can regain the concept of community care and family medicine from the task-based, reductionist, commercial procurement system destroying it.

Screening

We envisage two kinds of screening. There is a general alertness to early diagnosis, risk factors and general well being that are embodied in the concept of family health described earlier.

There are also evidence-based population screening programmes, based on analysis which weighs the harms of false negatives and false positives against the benefits of early diagnosis.

These two approaches can reinforce each other. For example, opportunistic screening in the former can raise response rates in the latter whilst chance findings in the latter can provide an issue for discussion.

Clinicians need to understand both these mechanisms for early diagnosis.

Risk Factors

Clinicians need to understand the risk factors for the diseases they treat, be prepared to recognise them and intervene. Many health professionals find this difficult, as it seems intrusive. They need to be given the skills to do this. It will be easier in the kind of health service we are advocating.

THE CASE FOR DUAL ACCREDITATION

We believe there is a need for training programmes which create doctors dually accredited in general practice and in public health and with the intention of practising both.

Healthcare public health is one subspecialty of public health which would particularly benefit from such dual roles. This subspecialty applies public health skills to the processes of planning and managing health services. It could be enriched by the general practice component of dual accreditation.

We also believe that dual accreditation would provide a good basis for the role of neighbourhood public health lead described earlier.

TRAINING

It should be possible to arrange training for dual accreditation in less than the time it would take to complete both general practice and public health training independently.

If doctors on such a dual training scheme could spend some time in public health as one of their GP training placements, were able to undertake epidemiological research in their hospital clinical placements, and were able to contribute to a public health role in their practice during their GP registrar training, it should be possible for them to acquire public health competencies which would allow a reduction of one year in their public health training. If a year of their public health training was on a placement as a neighbourhood public health lead, this could count as six months of their GP training.

Accordingly, it should be possible to arrange training for dual accreditation in six and a half years rather than eight.

This would require the GMC to be prepared to recognise such dual accreditation programmes, and deaneries to be prepared to fund them. We believe they could play a significant part in recruitment to both general practice and to public health.

CAREER STRUCTURE IN PUBLIC HEALTH NURSING

Schools play an important role as a community, and as a force in shaping the communities in which they are situated. School nursing needs to be developed as the public health voice within the school community. Where school nursing has developed in this way, its practitioners have gained skills which (augmented by training as a public health specialist) would be of value in the new role of neighbourhood public health lead.

Health visitors are an essential part of the primary care team, and central to the public health team.

Training as a public health specialist should be recognised as one of the available career progressions for health visitors and school nurses, not an abandonment of nursing.

Health visitors and school nurses who become fully qualified public health specialists would be one of the sources of neighbourhood public health leads.

WORKFORCE PLANNING

To have a half time neighbourhood public health lead for neighbourhoods averaging 25,000 people would require, if implemented across the whole of the UK, about 2,600 individuals (1,300 wte).

We might assume that about 40% of these roles will be taken by dually accredited doctors, about 40% by public health specialists from a health visiting or school nursing background and about 20% from other backgrounds.

If we assume that about 40% of these roles will be taken by dually-accredited doctors and that perhaps 500 dually accredited doctors may work in healthcare public health or commissioning instead of in neighbourhoods, then we may have about 1,500 dually accredited doctors.

Assuming a 30-year career this would require us to train about 50 such doctors a year. However, bearing in mind the need to build up a group from virtually a standing start, and allowing for some uncertainty about future career lengths, it might be a good idea to start at 100 and then review in the future.

This would imply 600 doctors in dual accreditation training at any one time - about 25 schemes each with an annual intake of four and, when it has built up to producing its first output, each with 24 people in training.

If 40% of the roles are to be filled by public health nurses it will also be necessary to increase the number of public health nurses who progress into training as public health specialists. Additional public health training numbers should be created for individuals from this background who wish to work in neighbourhood public health.

INTERIM ARRANGEMENTS

Based on the above workforce planning assumptions it will be 15 years before the training scheme has produced enough dually accredited doctors.

In the interim several possible arrangements could be used:

- There are doctors who have already undergone both types of training who could be recruited.
- Public health specialists from other primary care backgrounds, such as health visiting or community development, could be recruited.
- Public health consultants who are not GP trained but who wish to work part time could be recruited.
- Doctors, nurses and community workers undergoing the training could fill the role under supervision as part of their training.
- A special programme of GP public health fellowships could be established so that existing GPs can take on the role. For some time to come, until a cohort of dual accredited doctors manifests, GPs with an extended role will be the mainstay of the public health neighbourhood lead role.
- The programme could be rolled out incrementally, starting with the most deprived neighbourhoods and the most committed neighbourhoods.
- We could temporarily train more than 100.

ORGANIC DEVELOPMENT

Whilst central organisation would be necessary in creating the new consultant posts and to make new money available, it would not be desirable to set up the process simply through a centrally directed reorganisation scheme.

Neighbourhood Health Committees should grow out of a process of community development and community action. For example, under the guidance of the neighbourhood public health lead, local practices might aim to develop patient participation groups and social prescribing whilst the local authority invests in community organisers, and the local health organisation increasingly consults with the local community about the services it requires.

Out of this process would arise the necessary commitment, both professionally and in the community, that would allow a Neighbourhood Health Committee to be established and to start work with a strong background of support and understanding.

COSTS

2,500 half time public health consultants will cost about £200 million including costs and secretarial support.

A budget of £6.5bn would allow an allocation of £100 per capita to fund local activities and initiatives. With a weighting for deprivation this would be an average figure - deprived neighbourhoods receiving more and affluent neighbourhoods less.

A family health programme requiring an hour a year with each family would need 10,000 extra GPs, but there may be offsetting savings, for example in screening programmes which could be carried out at the same time.

We are looking therefore at costs of around £8-10bn per annum to operate this programme across the UK. This needs to be a specific allocation of new money, additional to general investment in improved primary care facilities.

It is a large sum by comparison with public health funding, primary care funding or projected NHS growth monies. However, within the total NHS budget the idea that £8-10bn should be spent in this way does not seem disproportionate.

If we are to tackle the behaviours which cause obesity, diabetes, alcohol-related diseases, and if we are to achieve the kinds of changes in communities which are necessary to address climate change, we need to change behavioural norms and we need to address environments at a very local level. The achievement of these changes will be dramatically enhanced by active community involvement.

The spending of this money also fits other objectives of the government including the levelling up of opportunities in deprived communities (especially if there is an adequate weighting for deprivation).

PAY AND CONDITIONS FOR GPs

Task-oriented general practice has developed task-oriented forms of payment and has driven productivity to carry out more tasks rather than to achieve population outcomes.

This has turned general practice into a treadmill. It is not surprising that most GPs, faced with a suggestion that they should do more work in public health, can only see that as a source of further tasks that will drive the treadmill more quickly.

DIU has in the past always believed that a salaried system is the best model for freeing doctors to work professionally. We understand the argument that an independent contractor system protects doctors from being directed by centralised authorities.

However, if it degenerates into a task-based remuneration system it does not achieve that objective. Equally we would not want to see a salaried system which tied GPs into being corporate servants of companies engaged in competitive procurement exercises, and focused on gaming the incentives on offer.

We support the NHS Reinstatement Bill which would bring the NHS back into public ownership and control. Continuation of our past support for general practice being predominantly salaried is dependent on that Bill, or one like it, becoming law.

It is necessary to have a system in which GPs are:

- Employed by (or contracted to) a public authority, which could be a local authority.
- Guaranteed free speech and the right and duty of independent advocacy.
- Focused on their individual relationship to their patients and their population relationships to their neighbourhood.
- Accountable to patients and colleagues, through the Neighbourhood Health Committee, not to centralised management systems.
- Committed to the work of their neighbourhood.
- Protected from bullying.
- Provided with support and resources instead of having to secure them at their own expense.
- Freed from the role of practice administration unless they choose to undertake it in which case they should be allocated time for it within their remunerated hours.
- Allocated time for special interests, study and research within their remunerated hours.
- Rewarded for outcomes not by bean counting.
- Driven by Parliament, professionalism and the people not by bureaucrats, beancounters and business managers.

Once a publicly owned and controlled NHS has been established as a People's Industry, with the concept of partnership between users and staff implicit in the People's Industry concept, such a system would naturally be a salaried system. We believe most GPs would welcome this.

We appreciate that amongst those who do not wish to be free of the burden of practice administration, there will be some who will wish for the option of a contract for services with these same characteristics. Many GPs wish to focus on clinical work, public health work and service planning rather than on managing their practice and would prefer these principles to be met by a salaried contract, but there are others who do like to manage their own practice and would prefer a contract for services meeting these principles.

PAY AND CONDITIONS FOR PUBLIC HEALTH CONSULTANTS

The neighbourhood public health leads should be paid part time as public health consultants, and should have their role as advocates and change agents fully recognised within their contract.

The current arrangements for employment of public health consultants whether in local government or in Public Health England do not make adequate provision for

their role as independent advocates and change agents. Consultants in local government are underpaid in comparison with those employed in PHE or the NHS.

A new consultant contract for consultants in public health is needed which should:

- Be applicable across all employers, including PHE, the NHS and local government.
- Recognise public health consultants as medical specialists and pay them on the same rates as consultants in other specialties. This is currently the case for medically-qualified public health consultants in the NHS, PHE and those local authorities which follow the PHMCC guidance on job evaluation for public health specialists. It is not however the case for consultants from the non-medical route of entry nor is it the case in most local authorities.
- Emphasise that their role is not merely internal to the affairs of their employing authority but is a professional role of a health professional treating a population.
- Define their role as being a change agent for improving the health of the people.
- Clarify that this role extends across local government and the NHS.
- Clarify that it also extends to advising other public agencies and to establishing relationships with private and voluntary bodies where they have the potential to support health improvement.
- Clarify that their duty to give honest advice to that population outweighs their corporate duty to their employer and overrides any provision of that authority's communication strategy. It is the duty of an employer of public health professionals to support them in their professional function.
- Distinguish the managerial role of public health consultants, where they have the same accountability as any other manager, from their professional role as advocates and change agents where their professional freedom must be maintained.
- Not involve civil servant status. Where it includes political restriction, it must be clarified that the purpose of political restriction is not to prevent comment on matters of political controversy but is the exact reverse - it is to ensure that when consultants comment on such matters they are seen to be doing so from a health perspective unaffected by party loyalty.

Whilst some local authorities have made a success of the current arrangements, it would in most cases be better if Directors of Public Health and their staff were employed jointly by local government and the NHS.

It would be even better if Directors of Public Health were independent offices constituted as corporations sole with the status of an NHS body and with statutory duties and powers within both local government and the NHS.

The distinction drawn in the Health and Social Care Act 2012 between "the health service" and "the NHS" should end. "The NHS" should apply to the whole of the

health service established under the National Health Service Acts. Public Health England should become an NHS body.