



The Royal College of **Pathologists**

Pathology: the science behind the cure

Response from the Royal College of Pathologists to Consultation ECR0171 Role and performance of Public Health England (PHE)

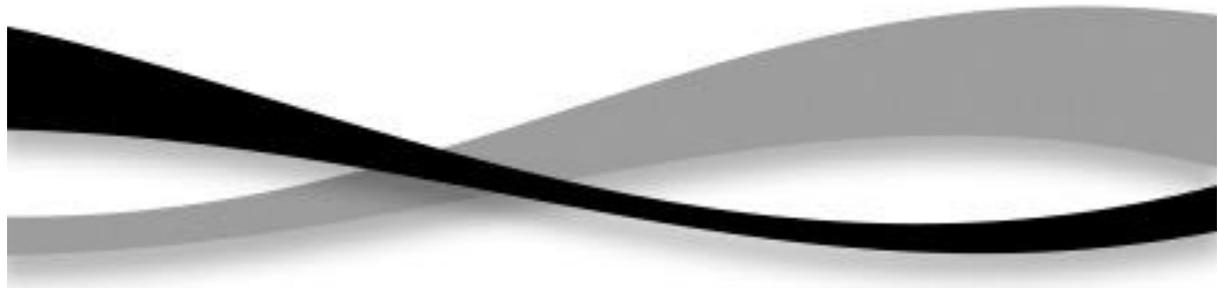
The Royal College of Pathologists' written submission

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1 About the Royal College of Pathologists

1.1 The Royal College of Pathologists (RCPATH) is a professional membership organisation with charitable status. It is committed to setting and maintaining professional standards and to promoting excellence in the teaching and practice of pathology. Pathology is the science at the heart of modern medicine and is involved in 70 per cent of all diagnoses made within the National Health Service. The College aims to advance the science and practice of pathology, to provide public education, to promote research in pathology and to disseminate the results. We have over 10,000 members across 19 specialties working in hospital laboratories, universities and industry worldwide to diagnose, treat and prevent illness.

1.2 The Royal College of Pathologists response reflects comments made by Fellows and members of the College during the consultation, which ran from 18th May 2016 until the 10th June 2016 and collated by Dr Rachael Liebmann, Registrar.

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2.1 In response to the question of whether PHE performs necessary functions, College Fellows and members considered that from an infection perspective PHE provided appropriate and effective help and support in outbreak situations. They were considered also to provide external scrutiny and support for NHS trust management of incidents and outbreaks and a source of expert knowledge and advice.

2.2 However, Fellows and members of the College were concerned about the recent disinvestment in the public health microbiology collaborating laboratories (31st March 2016) and the planned closure of 2 out of 5 of the national food and environmental laboratories. This raised concern that PHE may no longer be able to meet its objective of 'Protecting the public's health from infectious diseases.' It was considered that more local support and activity would increase the effectiveness of PHE.

2.3 When considering how PHE prioritised issues and how well PHE performs, College Fellows and members responded that PHE prioritised effectively and as a result there were robust mechanisms to protect citizens from communicable disease.

2.4 However, when asked to consider whether PHE is efficient and provides good value for money some of the respondents commented that some of the PHE surveillance (particularly E. coli bacteraemia surveillance) seems overly complicated and tedious and is considered by professional pathologists in the field not to be producing any useful actions. There was also a comment about the lack of PHE funding for PVL testing for Staphylococcus aureus despite the public health nature of some of this testing.

2.5 While respondents commented that more PHE input to emergency planning for mass fatality incidents such as pandemic 'flu would be desirable as some local authorities had no effective policy or plan for such an event, nevertheless with regard to non-forensic autopsy work PHE were considered to have been very helpful. For example in drafting the Ebola autopsy guidance, RCPATH was very grateful for the input received from PHE. Also in responding to specific questions from Fellows concerning the level of risk posed by infectious bodies PHE had been very helpful. In this aspect of their work RCPATH could not provide the same level of advice and guidance without the help of PHE.

2.6 In addition College Fellows and members work closely with PHE through the various cancer screening programmes and their associated Quality Assurance (QA) schemes. With regard to this contact there appeared to be some differences in the experience of respondents depending on the particular QA scheme to which College Fellows belong. The NHS BCSP was described as acting as a nodal point for all information, ensuring quality and setting standards and were regarded as having an open culture encouraging the reporting of any problems or adverse incidents.

2.7 However, regarding other cancer screening QA schemes College Fellows and members raised the following concerns:

2.7.1 The organogram for QA now shows a structure with a top heavy and excessively centralist accountability characteristic, which is considered unlikely to work well.

2.7.2 Amidst budget cuts, PHE was considered to have been very "hands-off" over the educative and professional direction element of regional NHS breast screening quality assurance schemes - aiming more for a tick-box system over data. It may be argued by PHE that professional leadership and education might be the role of others, but they have left a gap and have not sought to discuss this or how it might be filled with professional bodies such as the Royal College of Pathologists.

2.7.3 PHE's lack of understanding of pathology at bench level was considered to result in a bizarre effect on screening EQAs. Examples were given:

i) Cervical Cytology EQA - A very tight schedule for slide set rotation with short notice and short dwell times of slides in the laboratory - particularly in the first round run by PHE.

ii) Breast screening pathology EQA - the most recent cycle has started while the website is being physically moved so there is no access currently for members of the EQA scheme to enter their opinions and complete their input as part of the cycle.

2.8 With regard to the governance of PHE, College respondents commented that all four of PHE's functions should be undertaken; i) protecting the public's health from infectious diseases and other public health hazards, ii) improving the public's health and wellbeing, iii) improving population health through sustainable health and care services and iv) building the capacity and capability of the public health system.

2.9 However, College members and Fellows did not consider that support for these four functions was the same as continuing all of the activities shown in the PHE pictogram in the same section of the consultation. Specifically it was commented that PHE has little expertise

in developing and enacting global health policy and as such this policy role is not needed as it is provided elsewhere in government. It was considered that PHE can contribute to global health through individual professional/scientific expertise (for example by direct interaction with ECDC and WHO) or where requested could provide specific scientific capabilities in an emergency. However the current global health policy activity duplicates the activity of other organisations, is poor value-for-money and distracts staff from more useful UK-centred activity.

2.10 While some activities are cited as performing extremely well: egg. Professor Newton's knowledge division's output and summary of national data; national infection surveillance data; antimicrobial drug resistance, activities around obesity; local health protection in support of the NHS and individual professional knowledge and expertise, it was considered that the effectiveness of many other excellent staff and units was diminished by poor senior management.

2.11 Specifically it was noted that there was an erosion of PHE's scientific/medical expertise due to the loss of professional staff especially in the area of infections and health protection. This appeared to College Fellows and members to be linked to;

2.11.1 a wasteful and demoralizing internal power struggle over who would be in charge of which divisions and sections between the heads of health protection and infections;

2.11.2 widespread problems with senior management in microbiology at its main Colindale hub and more widely demonstrated by poor performance in the published PHE Staff surveys in 2013, 2014 and 2015. Worryingly, the position across the three staff surveys for key questions is not improving is well below the average across the Civil Service and that of the best scoring departments. Examples cited were; the proportion of staff wanting to leave the PHE within the next year is 27%; only 30% of PHE staff feel that leadership and change is well managed and only 31% of staff "feel it is safe to challenge the way things are done in PHE."

2.12 PHE was not considered to demonstrate the level of independence which would be expected by College respondents to the consultation. The Parliamentary Health Committee indicated that the PHE was not sufficiently independent two years ago and this seemed to be the case still to RCPATH Fellows and members. Specific examples of politically driven decision-making not rejected with independent scientific/intellectual rigour by PHE were;

2.12.1 temperature screening at ports to in an attempt to prevent Ebola and

2.12.2 disinfection of aircraft in an attempt to prevent Zika.

Neither of these were considered to be efficient or cost effective.

2.13 The College received comments that PHE decision-making was dominated ('obsessed') by process, being seen to approach things in a certain way and with organisational structures/restructures rather than functional needs and outcomes. Comments were made that within PHE protocols were enacted which involved unnecessarily large numbers of people in a very rigid hierarchy, and extreme caution, resulting in massively complicated processes being constructed to address low risk scenarios and hence providing a degree of

self-justification for such protocols and procedures. This approach was considered to be neither efficient nor cost effective.

2.14 Unfortunately, linked to the comments above, College respondents commented that overall there was a concern that PHE tended to pass responsibility around (“Oh, that’s my assistant’s job” etc), with no one taking ultimate responsibility for effective action and that, importantly, it was considered that a screening incident ‘would be more likely now that PHE are involved due to the more distant relationships that now apply’.