March 2011 **Paper 1**

Cheshire East Council Response to Consultation

Healthy lives, Healthy people: Our strategy for public health in England

On 30th November 2010, the Government released the white paper *'Healthy Lives, Healthy People: The strategy for public health in England'.* The paper states its aim as 'putting local communities at the heart of public health' and outlines an approach it believes 'will empower local communities, enable professional freedoms and unleashing new ideas based on the evidence of what works, while ensuring that the country remains resilient to and mitigates against current and future health threats'. It outlines the Government commitment to:

- protect the population from serious health threats;
- help people live longer, healthier and more fulfilling lives;
- improve the health of the poorest, fastest.

Earlier health papers and reports have guided the Government's approach, including Sir Michael Marmot's '*Fair Society, Healthy Lives'* report, '*A Vision for adult social care: Capable communities and active citizens'* and *'Equity and excellence: Liberating the NHS'.*

The white paper is separated into five sections:

- Seizing opportunities for better health
- A radical new approach
- Health and wellbeing throughout life
- A new public health system with strong local and national leadership
- Making it happen

Summary of key points

- The paper confirms that local authorities will be tasked with improving public health, fighting obesity, alcohol and drug abuse, smoking, and sexually transmitted diseases.
- The Director of Public Health will be the strategic leader for public health and health inequalities in local communities, working in partnership across public, private and voluntary sectors.
- There will be a renewed focus on bringing health work into early years, schools and unemployment initiatives.
- There will be ring-fenced budgets for public health. These are to be determined, but authorities may receive bonus payments for delivering on obesity and smoking targets.

- The guiding principle is 'reach across and reach out' – reach the root causes of poor health and reach out to people most in need.
- The support to be provided by local authority public health teams will need to be responsive, resourced, rigorous and resilient.

Consultation questions and responses

a. Role of GPs and GP practices in public health: Are there additional ways in which we can ensure that GPs and GP practices will continue to play a key role in areas for which Public Health England will take responsibility?

GPs can have substantial impact on the public health agenda as set out in Healthy Lives, Healthy People. However this will require a fundamental rethink about the way contracts by the NHS Commissioning Board are designed, the way in which delivery of public health outcomes are incentivised and the way in which GPs and GP practices become part of the wider public health delivery system.

The primary influence on GPs will be through the contracts they agree with the NHS Commissioning Board. Delivery of the wider public health agenda needs to be a fundamental part of these contracts, and not added as an afterthought. The public health agenda will then have a firm foundation nationally. In addition, all areas of Public Health England's responsibility will have broad coverage. These contracts should be based on sound evidence which is clearly communicated to GPs.

Additionally, at local levels much can be achieved by GPs' contributing to the development of the local Health and Wellbeing Strategies, agreeing priorities and delivery mechanisms designed to deliver best outcomes for communities.

All GP practices, in addition to all the GP consortia, must continue to have regular contact with Public Health England and governmental bodies. This should ensure that they receive consistent information and national guidance on the operational duties of all agencies involved in the Public Health Service in England. All GPs, including those that don't play an active role within their consortium, will need to receive information on national policy and their public health commitments, via the consortium.

Robust monitoring and accountability for commissioning and delivery of public health services are currently not in place. There is an assumption that GPs and GP Practices have a good understanding of public health and the needs of the population they are serving. Predominantly GPs and Practices are focused upon disease or special interests and often fail to recognise wider determinants. Building the capacity to address public health commitments should be a priority for consortia.

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

Availability and use of good sound data will be a core requirement for an evidence-based public health system. Public health information and intelligence is essential to ensure that the limited resources within the public health service, both monetary and personnel, are targeted to protect the population from serious health risk and to reduce inequalities in health. The prioritising of health risks and inequalities will be dependent on the availability of accurate local and national health statistics and data. Currently this information is made available by Regional Public Health Observatories, Primary Care Trusts, Local Authorities and Joint Strategic Needs Assessments.

The government's proposal to alter the Public Health Service in England must include and consider how to make information and intelligence available, readily accessible and accurate. Local government and GP consortia will require reliable data available in order to make informed decisions on local health priorities.

Improving access, quality and utility of data, and clarifying accountability and data sharing protocols will be a will be a major piece of work requiring robust standards. Various issues currently exist – for example the quality of practice information and disease registers is variable, and often practice systems are incompatible and practice information is difficult to access.

Work also needs to be undertaken urgently to understand what data is currently available, and how it can best be integrated at both local and national level. This should be followed up by a systematic approach to data integration.

Work in this area will need to be sufficiently resourced – requirements may currently be underestimated.

Utility of data has to be enhanced by underpinning it with good analysis. This will mean enhancing the skills pool and making best use of the skills available, for example by pooling resources.

Some thought is required on how public health professionals located in Local Authorities will have access to practice information including disease registers, Quality Outcomes Frameworks and population demographics. Mortality and morbidity information on certain data bases are only accessible to NHS employees through secure NHS systems which are used for needs assessments, equity audits and planning of services. This will need to be addressed with guidance.

Data quality is also a key issue under the new arrangements, where 'any willing provider' may provide a service. A fundamental requirement for good and reliable data is good quality entry at source. Data-keeping and quality requirements should form a key part of contracts with service providers, to prevent the data issue of 'garbage in, garbage out'.

c. Public health evidence: How can Public Health England address current gaps such as using the insights of behavioural science, tackling wider determinants of health, achieving cost effectiveness, and tackling inequalities?

Establishment of the National Institute for Health Research (NIHR) School for Public Health Research, and also of the Policy Research Unit on Behaviour and Health will go a long way to bridge the gap in this critical area. Capacity in each of these areas is likely to be scarce and scattered, therefore grouping to create cohesive units is essential. Effort will need to be focused at a national level to provide support and guidance from a central source. It will therefore be important to give both the NIHR and PRUBH a strong head start so that they are well positioned to meet the needs locally and nationally.

In the medium to long term local organisations will need to create and enhance this capability locally if they are to effectively tackle public health in a comprehensive way.

It will be essential to consider the root causes of poor health and health inequalities before they can be tackled. NIHR should be responsible for compiling and communicating research knowledge, successful policy modelling and professional experiences to improve health and reduce inequalities. This research will provide an insight into behavioural science, which is important in order to understand why health inequalities still exist within English society. People often have the knowledge of what is a healthy lifestyle but they choose not to practice their knowledge. The wider determinants of health include socio-economic status; education; housing; environment; workplace, society. All of these factors will have an influence on the health of an individual and their life expectancy. Research will also inform about cost effectiveness, which will be achievable if the limited available resources are used consistently to address the current gaps in health outcomes.

Research and policy modelling will need to be translated into practical advice. For example, a recent ‘Health Inequalities Toolkit’ provided practical assistance in addressing health inequalities, enabling national research to be applied locally.

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

Requiring the use of evidence in all that we do on public health will contribute considerably to an increase in the use of evidence across the public health system. At a practical level this will also mean publicising good practice examples, promoting the use of robust methodologies and rewarding best practice.

All partners should make evidence more easily and publicly available, both nationally and locally, and practitioners and commissioners should seek the use of evidence. This will assist in developing the culture of using evidence in public health.

It is important, however, that the focus and use of evidence does not become a trap and paralyse practitioners to indecisiveness and inaction, or impose an excessive burden on practitioners.

- Partners should ensure that a lack of direct evidence does not necessarily prevent an informed proposal from going ahead as a pilot, for example, provided the pilot undergoes thorough monitoring and evaluation – innovative approaches are to be encouraged.
- Partners should similarly consider whether spending many weeks or months undertaking extensive research and analysis and writing hefty reports prior to implementing an initiative is cost-effective, or whether it in fact stifles activity. The level of evidence-gathering undertaken needs to be appropriate to the scale of the activity.
- Partners should ensure that people with the correct skills are available to perform the different functions in using evidence – compilation of data, policy analysis, and application of public health expertise. This can greatly improve the efficiency of the process.

The knowledge and skills offered by national and local partners will be essential in order to tackle the inequalities in public health. Central and local government public health professionals will be able to contribute their knowledge and skills based on their previous experience. Partners could include both voluntary and commercial sector organisations and educational establishments, which will have an interest in promoting public health. They will have their own evidence base and experience of what has been successful within public health research. It will be important that health messages to the public are consistent, and if more partners are involved it will widen the spread of the message.

Distribution and communication of evidence and how this is understood by populations is a key role for local authorities, and could be supported by partner organisation such as Cheshire and Merseyside Public Health Network and sharing research from partners such as Age Concern, MIND, Macmillan, and the Roy Castel Foundation.

e. Regulation of public health professionals: We would welcome views on Dr Gabriel Scally's report. If we were to pursue voluntary registration, which organisation would be best suited to provide a system of voluntary regulation for public health specialists?

Local authorities traditionally have many practitioners that work in the wider field of health and wellbeing, rather than in healthcare-based public health. Regulation or registration is a positive way of recognising the role of these practitioners in public health.

The voluntary registration could be administered by the Chartered Institute of Environmental Health (CIEH) which has a history in protecting and promoting public

health and preventing ill health through controlling the spread of disease. Historically environmental health practitioners have played an important role in controlling infectious diseases, and as the wider determinants of public health have been identified, it has been responsible for administering national environmental influences such as clean air legislation. In 2007 environmental health professionals were responsible for implementing the most important public health legislation to date, the smoke free legislation in England. Many environmental health practitioners consider themselves to be public health specialists with recognised public health qualifications. They are dedicated professionals who lead existing initiatives within local authorities to promote public health, as well as working in partnership with Primary Care Trusts. The role of this profession will be vital in the government's plan for the future of the public health service. It is important that the invaluable contribution that environmental health practitioners play in improving public health and reducing inequalities is recognised by the government.