Chartered Institute of Environmental Health

Healthy Lives, Healthy People

Response to the Government's White Paper and associated consultations

by the Chartered Institute of Environmental Health

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Chapter 1

Executive summary

The CIEH welcomes the Department's ambition for improving England's public health performance.

The emphasis on the Marmot Review *Fair Society, Healthy Lives* fits exactly with the CIEH's analysis: a holistic approach is called for to achieve a significant step up in performance, focusing as much on the wider social determinants of health as the narrower healthcare-related determinants.

The need to focus on longer term improvements to health and well-being through preventative action, as advocated by Derek Wanless, should be embedded in the longer term strategy that will be required across Government.

It is reassuring that the Department's stated aim is to improve the health of all in England, and to improve the health of the poorest fastest.

In this response to the Department's White Paper and its five consultation questions, as well as the subsequent two consultation papers and the further 28 questions they contain, the CIEH concentrates on how to make a success of the Government's ambition and its public health policy. The CIEH stresses its willingness as a professional organisation and the willingness of its members as environmental health practitioners to get involved and to help make it a success.

The CIEH has concerns about aspects of the proposals, and these concerns are set out in the text below, but overall we want to explore how we can help. Crucially, the CIEH can see obstacles and pitfalls which need to be negotiated and where possible we point to ways of overcoming these difficulties.

It is a bold move to shift the lead for the local delivery of public health services from the NHS to local authorities. It is a move that is fraught with difficulties.

Nevertheless, the CIEH supports this move, sharing the Department's view that improving public health is everyone's responsibility and that local authorities, as community leaders and democratically accountable to the public, are best placed to engage all sections of our society in this public health challenge.

Many of the statutory powers for public health protection lie with local authorities and their officers, including environmental health practitioners. In the light of current reviews by other Government Departments it is important to recognise that these public health statutory powers provide the underpinning framework for many positive public health interventions.

As the major workforce already in local government with direct experience of delivering services relevant to all three pillars of public health, environmental health practitioners have a unique contribution to make through their prime focus of maintaining good environmental and public health.

Chapter 1

Executive summary continued

As a workforce already engaged in health protection and health improvement in every community, environmental health practitioners are key to providing the support to the Directors of Public Health that they will need in their new positions in local authorities to help deliver the new public health functions of local authorities at all levels.

Similarly, environmental health practitioners are well placed to make a success of the new Health & Wellbeing Boards. Ideally, practitioners would welcome a place on the Board, but if the Boards are small and places are limited, it will be all the more important that the members of the Board have in place mechanisms for receiving information and advice from local environmental health services.

In many places, environmental health practitioners are already engaged in collecting the evidence for, and actively involved in the preparation of, Joint Strategic Needs Assessments. It is anticipated that the JSNAs will become the cornerstone of the local public health strategy which the Department envisages that the Health & Wellbeing Board will develop.

It is essential that environmental health factors are fully reflected in both the JSNA and the local strategy.

Environmental health practitioners use problem-solving skills, supported by legal powers, to intervene in the causes of ill-health in the home, workplace and community. Their actions directly influence health and social determinants and maintain healthy environments for the benefit of both individuals and wider communities. At the same

Case study 1

In East Riding an environmental health officer co-ordinates a Health Through Warmth partnership involving the council, the NHS locally, National Energy Action charity (NEA) and npower. It operates through locally based partnerships.

Vulnerable clients whose health is adversely affected by cold and/or damp living conditions are referred for aid in the form of energy efficiency and heating measures along with related advice and information. This can involve benefit entitlement checks or referrals for smoke detectors or fire safety advice.

Training sessions for frontline health and community workers including social services, fire officers and voluntary groups are provided to ensure that every contact is potentially a health-improving contact because the right referral is made. All referrals are assessed by the environmental health officer and appropriate advice and measures are initiated according to the client's circumstances.

Chapter 1

Executive summary continued

time, they extend to the protection of the environment for future generations, as the CIEH set out, nearly a decade ago, in its publication Environmental Health 2012[1].

The Department's reforms represent a major challenge for local authorities in areas of England where there is two-tier local government and yet the White Paper is virtually silent about how this challenge will be overcome. There is real danger of fragmented services, duplication and inconsistency unless more attention is given to resolving this issue now.

The CIEH believes that it can help resolve this issue satisfactorily, provided that there is a statutory duty on public health partners to co-operate with and support each other. Such a requirement will not mean adding additional burdens or additional regulation to the public sector. This is the approach taken in respect of civil contingencies and safeguarding children.

It may then be left to local decision-making as to how best to arrange local public health services. The CIEH has a network of experts and experience of working with local authorities on projects to arrange services by joint agreement, shared services and consortia and can therefore assist in this work.

At the national level, the CIEH and environmental health practitioners have extensive experience of working in partnership with the Health Protection Agency. The CIEH has some concerns about the loss of the HPA's capability and expertise by reason of the decision to end its agency status and fold it into the new Public Health England within the Department.

Case study 1 continued

Funds are accessed from various national and local schemes, including Warm Front, CERT, fuel switch and charitable organisations. In the last 6 years over 2,500 referrals have been received and £4 million spent to aid clients for a range of measures.

East Riding, in partnership with Eaga, the Warm Front scheme manager, and the NHS have also undertaken mailings to ensure the public are aware of Warm Front funding. This has involved working on flu jab mail-outs and notifying all those with a long term condition of the benefit of a warm home and potential Warm Front eligibility.

'Changing Streets' is an additional programme of refurbishment works to pre-1919 private sector housing. These properties are classified as 'hard to treat' in energy efficiency terms as they are of 'solid wall' construction. This innovative scheme has, by the introduction of external wall insulation and loft insulation, significantly increased thermal comfort and reduced carbon emissions and annual fuel costs. The programme reduces fuel poverty and improves the health of residents in this relatively deprived area of Goole.

1 Burke, S., Gray, I., Paterson, K., and Meyrick, J. (2002), Environmental Health 2012 – A Key Partner in Delivering the Public Health Agenda, Health Development Agency, London.

Chapter 1

Executive summary continued

The CIEH is particularly concerned about the loss of an authoritative, independent voice in very important matters of health protection. This concern is matched by a worry that there will be a reduction in the resources currently provided by the Health Protection Agency, for example the Health Protection Units and the Regional Microbiology Network. These are important parts of the health protection system.

The White Paper is not clear on any of these issues.

Equally of concern following the recent Godstone Farm E.coli report, is the need for clear co-ordination of responsibility and action for protecting businesses and the public from infectious disease and contamination, a role that the Health Protection Agency, the Health & Safety Executive and local authorities share and where the need for improvements has been identified.

Whilst welcoming the creation of Public Health England, the CIEH believes that more needs to be done to ensure that the HPA's positive values are retained in the new set-up. For these reasons the CIEH proposes the appointment of a Chief Environmental Health Officer for England, working as part of the Chief Medical Officer's team and able to advise Public Health England, Parliament and the public on all aspects of environmental health. Such a post already exists in Northern Ireland and in Wales.

In addition, the CIEH believes that the new Public Health England will be stronger if it has formal links with public health partners and other public interests through the formation of an advisory forum attended by those with appropriate public health interests.

Developing an effective public health workforce will be essential. Environmental health offers a model of setting rigorous standards for entry to the profession, a compulsory requirement for continuing professional development and this is all achieved through self-regulation. The education curriculum, the professional standards and the skills requirements – for example in respect of competence and leadership – are all capable of development as the demands on the profession change.

The CIEH believes that this approach offers a regulatory framework that is proportionate and effective. It is an approach which balances a degree of independence for environmental health practitioners and their professional body with appropriate accountability of both to employers of practitioners and the public they serve.

The CIEH argues that this approach is capable of being broadened out to provide greater assurance in respect of the wider public health workforce. In the past the CIEH has contributed to the development of National Occupational Standards for public health. It has also been a partner in the creation and operation of the current voluntary UK Public Health Register – indeed, the CIEH provides the home for the register and its staff.

In all these areas the CIEH believes that it and its members have more to offer the Government and the other public health partners in the successful setting up and subsequent running of the new public health service in England.

We want to remain involved and to help.

Chapter 2

The CIEH’s vision for environmental and public health

Our vision is a healthy England where there is great public health and any health inequalities are insignificant. We want to see full implementation of the recommendations of the Marmot Review in *Fair Society, Healthy Lives*.

To achieve this vision requires the active involvement of everyone: citizens, communities, businesses, voluntary and not-for-profit organisations, professional bodies, local government, NHS, Public Health England and all of central government. We all have a responsibility for public health.

The environmental health profession is but one partner among many in making this vision happen. However, we have the ability to be an important catalyst for change.

A local authority is a community leader and is accountable to its community through the democratic process. A council has many roles including as an educator, service provider, planner, in procurement and as a significant employer itself. In local government, environmental health practitioners already work with businesses (including small businesses), community groups, landlords, NHS partners including Directors of Public Health, GPs, hospitals and primary care trusts, schools and voluntary organisations. They contribute hugely to the council’s health protection and health improvement programmes.

In the commercial and not-for-profit sectors, environmental health practitioners already work with their employers to improve their businesses through advice, guidance and the application of regulation in accordance with better regulation principles, for example:

- Ensuring that food processes are hygienic and safe; and
- Ensuring that occupational health and safety requirements are proportionate to risk and keep workers, contractors and visitors safe from death, injury and illness.

They work through the supply chain to uphold safe practices beyond their employers’ businesses. They protect the public, consumers and business from unsafe practices creating a level playing field for entrepreneurial growth.

In many other settings – academic, consultancy, statutory regulators and training – environmental health practitioners already work to maintain and improve public protection and safety in ways that contribute to good public health.

As society changes, the public health threats and challenges change, too. The ease with which people now travel internationally, the lifestyle changes and the growing reality of serious climate change, for example, are developments that bring us face to face with the need to adapt behaviour and services, especially public health services.

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Environmental health practitioners already work on the health protection and health promotion responses to such changes. From helping prepare for new pandemics and more exotic diseases, tackle the rise in obesity and prepare for more sudden flooding and greater excesses in cold and hot weather, environmental health practitioners are already on the case and they will be part of the solution, taking the action needed to keep us all safe.

Some people understand that environmental health practitioners exercise statutory powers to protect the public from food poisoning, ensure safe housing conditions, uphold high levels of occupational safety and health, and prevent pollution of our air, land and water. Environmental health extends to pest management and vector control – an essential function for public health and well-being. But too few appreciate the diversity of the regulatory instruments and activities crucial to maintaining and promoting good public health and preventing adverse outcomes.

Some people understand that environmental health practitioners carry out health protection functions that protect us from serious cases of infection and contamination, exercise the statutory powers to take the urgent action necessary to prevent infection and contamination and work with other health protection partners such as Health Protection Units to identify and trace causes of infection and contamination in order to prevent adverse outcomes. But too few appreciate how vital this work is to promoting good public health and preventing potentially disastrous incidents.

Case study 2

A Sunderland environmental health practitioner (a Health Promotion Specialist) works in a health promotion team involving Environmental Health and Trading Standards. One focus of public health is the annual Healthy Home award. Residential and nursing homes across the City are inspected and assessed against the award's criteria of good standards of hygiene, trained staff, good health and safety procedures and practices, including looking at care plans and risk assessments. The staff, residents and their families are also helped to enjoy a smoke free environment and referral to the smoking cessation service is offered. In addition, menus are assessed for healthy and nutritional diet and the activities offered to residents are assessed for their health improvement capacity. The team offers advice and support to the homes and it helps them contribute to the standards demanded by the Sunderland Quality Standards for Care Homes.

A total of 24 care homes with over 800 service users received the award for 2010/11, the number of homes applying for an award for 2011/12 has doubled and includes some smaller homes for young adults.

Chapter 2

Some people understand that environmental health practitioners carry out health improvement activity that improves public health and reduces health inequalities, working with partners to improve lifestyle choices such as diet, exercise and smoking cessation, improving housing conditions by reducing slips, trips and falls hazards and increasing energy efficiency, as well as tackling sources of excessive noise that otherwise impact adversely on physical and mental wellbeing. But too few appreciate that so much improvement is being achieved with a wide range of partners and that improved public health and reduced health inequalities is the result of this work.

Some people understand the vitally important work carried out by environmental health practitioners at our UK ports of entry to prevent the importation of diseased and dangerous goods and materials, protect our food animal stocks from animal health hazards such as foot and mouth disease and swine fever and prevent the entry of rabies or new pest species into the public realm. But too few appreciate that these controls are vital to protect the country as our first line of public health defence, which must be retained.

So our vision is for the value of this environmental health workforce to be recognised and fully incorporated into the new public health services, nationally and locally. The way we are capable of working holistically, with communities and businesses and with all the full range of partners, makes us ideal for the public health challenge ahead of us.

These various roles we carry out should not be seen as separate and distinct. Instead, look across the full range and see how much more an environmental health workforce, properly integrated into the wider public health workforce and guided by this vision, can achieve.

We will work hard to collect and supply relevant evidence for the Joint Strategic Needs Assessment. We will contribute to the Health & Wellbeing Boards' planning of the local public health strategy. We will work with the full range of partners to deliver services in line with the strategy. We are good at engaging with Government, citizens, communities and businesses to achieve behaviour change and reinforce the central message of personal responsibility.

Above all, we want to bring into the new public health service the core holistic approach to public health that we already demonstrate and we believe so clearly, we have something valuable to offer. We are good at what we do and we know we can help make a difference.

Chapter 3

The CIEH's response to the White Paper Healthy Lives, Healthy People

The CIEH welcomes the Department's confidence in local authorities to lead on public health services in England at the local level. We support the proposal in the White Paper to shift the public health lead from the NHS to local government. The CIEH has long argued that this should be so. We quite see how this move fits with wider Government policies for localism, greater democratic involvement in matters that so crucially affect people's lives and the greater emphasis on personal responsibility at all levels of our society.

Local authorities have statutory responsibilities and powers to provide regulatory services covering a wide range of activities impacting on public health including food safety, health and safety at work, communicable disease, pollution control, housing, and licensing. Local authorities are also under a duty to develop a community strategy, in consultation with partners, which sets out how they will promote the economic, social and environmental well-being of their local community.

These responsibilities are currently under review by Government and we will be responding separately on this. It is important to consider all these functions as part of a "whole systems" approach and an integral part of the existing public health infrastructure.

These responsibilities may be carried out through a variety of activities including advisory, education, enforcement, licensing, health promotion, and working with partner organisations with the consistent aim of ensuring compliance with our society's standards and the protection of public health.

The environmental health workforce is the only comprehensive and professional public health delivery service in local government. This means that there is a ready-made workforce able to help Directors of Public Health deliver their new public health functions and to work with other colleagues at all levels, directly providing core public health services, especially in health protection and health improvement.

The availability of this experienced, versatile and "can do" environmental health workforce is threatened by the spending cuts that have forced local authorities to shed many jobs. There is a serious risk that the very capacity needed to make a success of the Department's public health plans will no longer be in place in 2013 when the new local service is due to start.

There is also an urgent need to demonstrate that the new services, both national and local, will be adequately funded when the services are launched. It is essential that the total available funding for the three pillars of public health in England (health protection, health improvement and population healthcare) is disclosed as soon as possible.

Chapter 3

The great majority of the funding for the new public health services to be led by local authorities should properly be provided through direct grant-funding. The grant should be appropriately weighted to reflect levels of deprivation and health inequality and the formula used for assessing and distributing the grants to local authorities should reflect this.

It is right that at the outset of these new services the grant funding should be ring-fenced. It is clearly vital that the new services are launched successfully and there is a great deal of work to be done in a short space of time to ensure this success.

Conversely, the health premium, intended by the Department to incentivise a successful public health performance by local authorities, runs counter to the Government's ambitions for a successful launch and for enhanced localism.

There is a danger that a plethora of confusing outcomes and indicators, linked to short-term performance of long-term public health objectives will make the overall distribution of funding for the new services obtuse, perverse and unfair.

The White Paper, and the Bill, the latter having already commenced its passage through Parliament before this consultation has closed, are virtually silent on the challenge faced by many parts of England where local government is two-tier. In the CIEH's own consultations about the White Paper, this is an issue which has been raised over and over.

In such areas of England, the Department proposes that the County Councils shall have the statutory powers and duties, the ring-fenced funding and the services of the Director of Public Health, yet the only specialised workforce capable of delivering on the public health agenda is almost entirely with the Borough and District Councils.

The CIEH believes that it can help fashion a solution to this challenge but it requires commitment from the Department to provide the right statutory framework. It is essential for the law to require the various councils to co-operate and support each other, and require involvement of the Borough and District Councils in all the relevant arrangements.

The CIEH believes that the arrangements for Borough and District Councils should include a right of access to the new Health & Wellbeing Boards, preferably through a seat at the table and an input into the Boards' deliberations.

The CIEH is confident that local government, Public Health England, the NHS, businesses, professional bodies, voluntary and not for profit organisations and local communities can work together to improve England's public health performance.

Chapter 3

The CIEH entirely agrees with the White Paper's approach to improving the health of the poorest fastest and reducing health inequalities. We completely support the recommendations of the Marmot Review set out in its report *Fair Society, Healthy Lives* (February 2010) as evidenced by our recent joint event with the Marmot Review Team on this very point.

At the same time, the CIEH is mindful of the evidenced-based longer term need to reduce the future burden on the NHS by preventative strategies that have long term positive health outcomes like reducing obesity, alcohol consumption, and the social gradient of ill health.

At the national level, the CIEH gives a cautious welcome to the creation of Public Health England. We welcome the drawing together in one body of the relevant expertise and experience. In its creation England has the opportunity to ensure that a whole systems approach is able to be applied to the very complex interactions that make up the public health challenge.

We welcome the intention to improve the collection, evaluation and dissemination of relevant public health data (with a number of new initiatives) and Public Health England has a useful role to play in analysing, prioritising and promoting the appropriate use of such data.

The CIEH is concerned that the independent voices of bodies like the Health Protection Agency and the National Treatment Agency will be lost, with no proposal to introduce any substitute sources of independent advice and advocacy and no proposals to otherwise counteract this loss.

The CIEH has two specific propositions to make to help remedy the loss of independence and bolster the ability of PHE to speak out on public health issues, matters in which the public has a legitimate interest.

The CIEH's two specific propositions are:

1. There should be a Chief Environmental Health Officer, working as part of the Chief Medical Officer's team and able to advise Public Health England, Parliament and the public on environmental health aspects of public health. There has been such a position at times in England's history and there is such a post today in other parts of the UK.

2. Public Health England should be assisted in its work by an advisory panel (or forum) comprising representatives of the public and of relevant public health interests, including environmental health. This approach enables Public Health England to stay in touch with public health practice and the public's priorities as well as test out its thinking on a knowledgeable yet independent body of people.

Chapter 3

A Chief Environmental Health Officer will provide a professional focus in the Department to maintain the necessary breadth of view and holistic approach to policy formation and implementation. It is essential that Public Health England, the Government, Parliament and the public have the high level perspective on key environmental health risks and their contribution to public health that a Chief Environmental Health Officer will bring.

A forum to support the work of Public Health England will ensure that there will be regular two-way dialogue, an exchange of information and regular input not only in respect of policy development and implementation but also feedback, evaluation and early warning. A wider public health network, with the forum at its heart, can only benefit the cohesiveness and effectiveness of the whole public health system in England.

Case study 3

Led by an environmental health practitioner, Hull's Promoting Healthier Food Choices Group demonstrates joint NHS and local authority partnership working. The Group works with the British Heart Foundation programme in schools to promote healthier eating. The Group also encourages retailers to promote healthier food choices with the objective that customers will choose healthy eating options.

In addition, work is undertaken to prevent the increase of takeaways near schools, as well as unhealthy vending in schools and sports centres. This Group provides the link between the public health teams and relevant departments within the local authority, including planning and leisure services, and the local NHS, including GPs and hospital doctors as well as community nurses, health visitors and dieticians.

Chapter 4

The CIEH's answers to the White Paper's 5 consultation questions

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?

GP practices already provide significant public health services in NHS primary care. It is important that they continue to play an active role in public health (health protection and health improvement as well as services).

The Health and Social Care Bill as currently drafted is too weak in ensuring that GPs will not only remain engaged in the broad spectrum of public health but also that they will, through the new commissioning consortia, commission healthcare services in accordance with the local priorities identified in the JSNAs and set out in the Health & Wellbeing Boards' local strategies.

The previous experience with Primary Care Groups demonstrated that there was a significant variation in the degree to which GP practices engaged with this wider agenda.

There must therefore be statutory duties to ensure that GPs maintain their existing contribution and commissioning services in line with local priorities.

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

Using evidence-based decision-making to determine the most effective interventions will be essential. There are roles for practitioners as well as academics in collecting and assessing evidence.

Environmental health practitioners already obtain evidence that arises through their local interventions and they should play a role in collecting and assessing evidence and advising on the policy implications.

This includes: involvement in collation of local evidence and advice for the JSNA; interpretation and analysis of the evidence; presentation of the JSNA to the Health & Wellbeing Board and interpretation of implications for local public services. In addition, it is essential that environmental health practitioners contribute to the debates to establish local priorities and are involved in the arrangements for delivering the services that give effect to the Board's local strategy.

Chapter 4

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?

The Department's new approach gives significant weight to personal responsibility, responsibility deals, voluntary approaches and "nudge not nanny". It is vital that Public Health England is in a position to provide evidence of "what works". The CIEH envisages that this will include guiding public health partners through the available data, including information about good practice that ought to be disseminated more widely and considered for adoption in more localities (recognising that the same solutions will not apply everywhere).

Environmental health practitioners are active in businesses, communities and localities and they are trusted not only by individuals but also by businesses, especially SMEs and, where they work for businesses, they are trusted and relied upon by their employers.

They are therefore well placed to take part in the new approaches adopted and promulgated by Public Health England, including involvement in and with businesses and communities providing assurance and confidence in respect of the effectiveness of "responsibility deals".

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

Environmental health practitioners are skilled at working in partnerships with others. The CIEH has case studies of projects involving environmental health and partners, including Trading Standards, schools, police, libraries, business organisations and other agencies like the Food Standards Agency and the Health & Safety Executive.

Environmental health practitioners are experienced in working with the Health Protection Agency and Health Protection Units in the prevention and control of infection and contamination as well as resilience planning.

As an educational, standards-setting and qualification awarding body, the CIEH also has wide networks and routes to influencing behaviour. The CIEH and environmental health practitioners have immense capacity to work with partners, including those named already and also academia, to share information as well as help disseminate information.

Chapter 4

5. 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?

It is essential to the securing of a sufficient and appropriately skilled public health workforce that issues of registration, standard-setting and upholding high standards should be addressed from the outset. At stake is the currently multi-disciplinary public health workforce in which healthcare, local government and other public health professionals want to plan and advance their future careers, right to the top of the public health service if that is their ambition and their capability.

Under the current arrangements, it is possible for Environmental Health and other non-medical professionals to reach the top levels of the public health workforce, including employment as Consultants in Public Health and Directors of Public Health. It would be a mistake to turn away from arrangements such as self-regulation by professional bodies and the voluntary UK Public Health Register, which could be the effect of embracing a rigid model of statutory regulation, probably based on an existing medical model.

The CIEH believes that one of the greatest potential strengths of a new public health system is the ability to draw the best people from a wide range of backgrounds.

The CIEH and many other organisations and individuals have worked hard to achieve a system for ensuring competence in public health professionals that provides for equivalence between individuals with medical and non-medical qualifications and seeks to unify the complex and multi-disciplinary public health workforce. This is in line with a proposal first made by Sir Donald Acheson and taken forward by his successor as Chief Medical Officer Sir Kenneth Calman.

The CIEH also believes that there is a continuing place for routes that lead to either generalist specialist or defined specialist status in public health.

The CIEH argues that a flexible, diverse system for upholding high standards of knowledge and skill in the public health workforce fits best with the Department's ambition for the new public health service and the Government's view of the proper role of regulation.

The CIEH therefore favours further development of forms of regulation and upholding of standards that exist already. This approach would include a more prominent role for the current UK Public Health Register.

Chapter 4

The UKPHR is an independent organisation with its own governance. Its Board and its advisory group engage with all the relevant stakeholders. Through its portfolio and developmental routes it has registered professionals from many different backgrounds to specialist status. It has recently started the process of registering practitioners, which allows a continuity of individual development over time as the necessary skills, competencies and experience are acquired.

The UKPHR is committed to keeping its processes under review and to work with the other regulators to ensure an equality of outcomes. The CIEH believes the UKPHR is capable of further development over time so as to provide sufficiently robust regulatory under-pinning, in addition to educational, training and competence standards, for the public health workforce. This is a pragmatic, flexible way to resolve a range of important workforce issues and is capable of continuing to operate alongside the other regulators.

For its part the CIEH is committed to being an active member of the UKPHR, as well as ensuring that its own accredited graduate and postgraduate courses reflect the need for its practitioners to play a full part in the new public health workforce.

The CIEH is in its own right an awarding body, with a Royal Charter that enables appropriate qualifications, including chartered status, in a variety of public health disciplines to be accommodated. The standards of practice and competence that the CIEH applies to members of the environmental health profession can be applied to other disciplines. The CIEH's systems of accreditation, curriculum development, registration and awarding chartered status provide an extensive reach across the spectrum of non-medical public health practitioners and could be applied to ensure that those who were not able to be recognised by the current register would be able to be accommodated.

The CIEH would be happy to discuss this issue further with the Department and would wish to be included in the discussions on the development of the public health workforce over the coming months.

Chapter 5

The CIEH's response to the Outcomes Framework consultation paper

The Department has made clear that its approach to implementing the public health service reforms will be the same as the Government's approach to other areas of public policy. New regulation will be kept to a minimum, targets will not be set other than as may be justified by reason of a sound evidence base for the intervention and guidance from central government will be kept to a minimum.

Localism instead will influence the priorities and the ways of working of the new public health service at the local level.

Individuals and communities will be able to influence and determine the priorities and ways of working. Personal responsibility will be to the fore as public health professionals and practitioners seek to bring about the behaviour change necessary to improve England's public health performance.

It would be unrealistic to expect the new local public health service and local communities to know how to proceed to achieve improvement without some support and direction. The Department proposes to put in place a number of supports: the new intelligence role that Public Health England will carry out, ring-fenced budgets and the Outcomes Framework.

As the White Paper makes clear, the Outcomes Framework is one of three such Frameworks (the others being NHS and Adult Social Services) and, intentionally, they overlap so as to demonstrate the inter-linking of these three sets of services.

The CIEH supports this approach and welcomes the consultation on the proposed Outcomes Framework. The Department of Health has made clear that the consultation genuinely seeks views on ways to improve the Outcomes Framework. This acknowledgement is welcome.

In general, the CIEH's view of the draft Outcomes Framework is that many of the proposed outcomes are relevant but that there are too few outcomes that address the "causes of the causes". We make suggestions for some additional outcomes below.

The CIEH cautions against the over-use of "indicators" in support of the outcomes, whilst recognising the desire for there to be evidence of progress in improving public health and reducing health inequalities. Some outcomes are difficult to measure directly and the risk is that any "proxy" indicator may divert attention from the main goals.

The CIEH's concern about the outcomes selected, the indicators used to measure progress and the assessment of performance at the local level is greatest in respect of the health premium.

Chapter 5

The Government’s wish to incentivise good performance is understandable.

However, in relation to public health there are two negative factors that militate against this approach:

1. Addressing public health deficits and health inequalities that are ingrained in a community requires a consistent approach over a long period of time. Some of the inequalities are so entrenched that they cannot be fully addressed in the lifetime of one Parliament. It follows therefore that there will be outcomes that will only be achieved long-term, yet the awarding or withholding of the health premium will, presumably, be an annual feature of the funding system. It seems inequitable to judge short-term performance, for the purpose of providing to or depriving a community of a resource, when the effects will be evidenced over the long-term.

2. The Secretary of State has said that the health premium will be withheld from a local authority with a poor performance. He has said that he will not be swayed by arguments from a local authority that local factors like levels of deprivation prevent the local authority from improving public health. This could potentially amount to denying a community a resource available to other communities if, say, health inequalities increase because of deprivation factors beyond the control of the council and its communities – for example, inward migration, air pollution and pest infestations, factors which transcend local authorities’ boundaries.

The Department has made an interesting proposal that a local authority will be able to choose from the Outcomes Framework a smaller number of outcomes to focus its efforts on locally. There is good reason for this.

Local priorities should be determined through carrying out the Joint Strategic Needs Assessment followed by consultation and debate led by the Health & Wellbeing Board and the adoption of a local public health strategy to guide the application of all available resources to those local priorities so identified.

If this proposal were to become a feature of the local public health service, the Department ought not to be overly concerned to restrict the total number of outcomes to be included in the Outcomes Framework.

In fact, there ought to be a sufficiently broad range of outcomes to ensure that local communities are able to choose outcomes that match the priorities that they care most about.

The CIEH therefore supports the inclusion in the draft Outcomes Framework of a number of outcomes that are relevant to environmental health practice. These are picked out explicitly in the answer to Question 6 in the next section.

The CIEH supports the inclusion of these outcomes in the final Outcomes Framework.

Chapter 5

The CIEH believes that there are other social determinants of health for which there should be outcomes in the Outcomes Framework.

It would not be difficult to incorporate appropriate indicators for these suggested outcomes where data is available.

Possible additional outcomes and indicators include:

- Category 1 hazards under Housing Health & Safety Rating System;
- Contaminated land;
- Empty homes rate;
- Food and water-borne diseases;
- Health effects of alcohol usage;
- Incidence of food poisoning;
- Prevalence of smoking in under-18s;
- Rodent population/incidence of domestic property pest infestations
- Workplace deaths, serious injury and serious illness rate.

There is a justification for the CIEH's suggestions in the answer to Question 6 in the next section.

Chapter 6

Answers to the 12 questions in the Outcomes Framework consultation

Q1. Consultation question: How can we ensure that the Outcomes Framework enables local partnerships to work together on health and wellbeing priorities, and does not act as a barrier?

The Department sets its face against targets (unless they are justified) and it will be important not to reproduce targets under a new name. The key is to keep the outcomes focused on public health objectives, ensure that they are widely regarded as the most relevant and desirable outcomes and avoid too much detail in the form of the indicators to be specified.

The CIEH's view of the draft of the Outcomes Framework is that many of the proposed outcomes are relevant but that there are too few "causes of the causes" outcomes in respect of the wider social determinants of public health and health inequalities. The CIEH suggests some additional outcomes in respect of the wider social determinants (answer to Q6).

The application of the new health premium, with funding to local authorities linked in some way to performance measured against these outcomes (or some of them) causes the CIEH particular concern. We have set out in the general text earlier why we are so concerned. We would urge that the Department's original proposals in this respect should be changed, and in particular, communities where there is severe deprivation ought to be assisted in addressing the additional challenges that such deprivation causes the community and local authority as they seek to improve public health and reduce health inequalities.

If the health premium is to be introduced and payment linked to some or all of the outcomes/indicators contained in the Outcomes Framework, it will be reasonable to ask that there is some recognition in the scheme of the mis-match between short-term funding and long-term outcomes.

While some of the interventions carried out by environmental health practitioners can deliver immediate and short term improvements in health and health protection, for example maintaining smoke free environments and preventing accidents, whether at work or in the home, a great deal of the EHP's contribution goes towards improvements in long term public health.

In these circumstances the Secretary of State for Health has spoken of the need for indicators that enable identification that a local authority is 'on the right road' to improving and maintaining public health in its locality. The CIEH welcomes this clarification. The CIEH offers some thoughts in answer to Q10, and is willing to work further with the Government to identify appropriate milestones.

Chapter 6

Q2. Consultation question: Do you think these are the right criteria to use in determining indicators for public health?

The criteria referred to are those to justify each individual indicator's inclusion, namely:

- Is it evidence-based?
- Does it reflect a major cause of premature mortality or avoidable ill health?
- Does improving this indicator mean that public health is improved?
- Will it be meaningful to the public health workforce and the public?
- Might it have an adverse effect on equalities for any specific population group?
- Is it possible to measure and to be used to set SMART objectives?
- Are there existing systems to collect the data?

As a set of criteria these seem appropriate. The challenge will be in interpreting and applying them when setting specific indicators.

Q3. Consultation question: How can we ensure that the Outcomes Framework, along with the Local Authority Public Health allocation, and the health premium are designed to ensure they contribute fully to health inequality reduction and advancing equality?

The CIEH feels uneasy about linking funding for a public health service to achieving progress against indicators (as the health premium for example seems set to do). However, it is right to have ambition to improve public health in England and therefore it is important to be able to assess whether or not the work undertaken in communities is making a measurable difference.

There is a general concern among the public health community, and which the CIEH shares, that the total funding allocations for the new public health service in England, however they are divided up, will be inadequate overall. This is so both in respect of the national service and the local services. In its response to the questions posed in the White Paper, the CIEH highlighted the reduction in resources that is taking place before the new service is set up.

It will be most unfortunate if the launch and early years of the new public health service in England are marred by arguments, claims and counter-claims about the insufficiency of the total funding or the unfairness of the allocation of funding between competing interests within the public health service overall.

Chapter 6

There also needs to be recognition that each area has its own unique mix of public health issues and demographics, and that interventions may have different impacts in different areas. The emphasis should therefore be on what has been achieved and on the relative improvement against the baseline for that area.

Q4. Consultation question: Is this the right approach to alignment across the NHS, Adult Social Care and Public Health frameworks?

Figure 1 on page 14 of the consultation paper shows the inter-action of the three frameworks and it is a helpful representation of the areas of common interest. It is unexceptional as an illustration of the overlaps.

The key issue will always be where boundaries are drawn between budgets and this is especially significant as between the three Government Departments whose budgets are involved.

The document draws attention to a new Transparency Framework that the Government has published under which all Government Departments have published their business plans. This is an initiative that should be followed up so that there is ongoing accountability and transparency regarding decisions taken centrally that will affect services delivered locally.

Some have been critical of splitting off public health from the healthcare system delivered by the NHS, with its own outcomes framework, arguing that there should be one framework covering the NHS and public health.

The CIEH feels that making them separate frameworks demonstrates that the nature of the public health service is different from the NHS whilst the areas of overlap demonstrate that joint working by the NHS and the new public health service in England will be an extremely important element in making a success of the new arrangements.

Q5. Consultation question: Do you agree with the overall framework and the domains?

The CIEH recognises the five domains and agrees that they are appropriate. The CIEH neither argues that there are other domains missing nor that any of the five proposed should be removed.

The outcomes and indicators are grouped by domain, which is helpful.

The domains are sufficiently broad and relevant so as to ensure that all the important environmental health contributions can be properly included and recognised. It is important however to recognise and take into account the contribution that other Government Departments and agencies should be expected to make to achieving overall public health and well being gains and to include this contribution in the overall framework.

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Q6. Consultation question: Have we missed out any indicators that you think we should include?

Many of the proposed indicators are relevant and helpful. The CIEH does not have a view about the appropriateness of the outcomes which are focused at the healthcare end of the public health spectrum.

On the other hand, the health protection and health improvement pillars might well be supported by more, appropriate, indicators. It would also be helpful to give more thought to the link between 'wellbeing' and mental health and the means of measuring success in improving both.

The CIEH welcomes the inclusion in the draft Outcomes Framework of a number of outcomes and indicators that are relevant to environmental health practice.

Examples include:

- All the proposed outcomes for health protection and resilience;
- All the proposed outcomes for tackling the wider determinants of ill health;
- All the proposed outcomes for health improvement;
- Hospital admissions caused by unintentional and deliberate injuries to under 5 year olds;
- Breast feeding initiation and prevalence at 6 weeks after birth;
- Work sickness absence rate;
- Proportion of persons presenting with HIV at a late stage of infection;
- Child development at 2 to 2.5 years;
- Maternal smoking prevalence (including during pregnancy);
- Smoking rate of people with serious mental illness;
- Health-related quality of life for older people;
- Acute admissions as a result of falls or fall injuries for over 65s;
- Mortality rate from communicable diseases;
- Mortality rate of people with serious mental illness;
- Excess seasonal mortality.

The CIEH supports the inclusion of all of these in the final Outcomes Framework.

Chapter 6

The CIEH especially points out the close inter-relationship between health and housing. It is welcome that a number of the outcomes make this link well, for example, those relating to housing overcrowding, homelessness, fuel poverty and excess seasonal mortality.

Living in an overcrowded home can affect the mental and physical health of the occupiers and the lack of privacy involved can affect child development. The HHSRS operating guidance states:

> "Crowding can result in an increase in heart rate, increased perspiration, reduction of tolerance, and a reduction of the ability to concentrate. Crowded conditions are also linked with increased hygiene risks, an increased risk of accidents, and spread of contagious disease.
>
> There appears to be no particular age group which is more vulnerable than others. However, those most vulnerable will be those who spend the most time at home, typically the elderly, the very young, the mobility impaired and their carers."

People who are homeless will be living in substandard and/or overcrowded housing, moving from one place to another or living on the streets. The health effects of living on the streets are severe and the street homeless have a significantly lower life expectancy than the figure for the bottom percentile of households.

Homeless people admitted to A&E are often twice as sick as the general public and cost eight times as much to treat (Guardian 23 February 2011)

www.guardian.co.uk/society/2011/feb/23/uch-london-hospital-homeless-people-treatment

They are also more likely to have a range of physical and mental health conditions, as well as problems with substance misuse. Young adults leaving care are also over represented and the life chances of looked after children remain below those for the general population in significant respects.

Those living in fuel poverty will be living in cold and often damp homes during the winter months, with the additional worry of paying their fuel bills. This can cause or exacerbate cardiovascular and respiratory disease and affect the mental health of those affected. The Department for Communities and Local Government in the Housing Health and Safety Rating System Operating Guidance (originally published by the ODPM) states:

> "Low temperatures can impair the thermoregulatory system of the elderly and the very young whose thermoregulatory system is immature. Both of these groups may spend a greater time indoors in cold weather and both these groups will not move about as much as other groups in the cold.

Chapter 6

> Cold air streams may affect the respiratory tract and can slow the heart temporarily, increasing cardiovascular strain. When the whole body is cooled, blood pressure increases. The effect of cold air on the bronchial lining and immune system can reduce resistance to infection. Thus, sleeping in cold bedrooms has been shown to substantially increase the health risk.
>
> The symptoms of rheumatoid arthritis can be worsened by cold. Low temperatures also aggravate sickle cell anaemia and the related thalassaemia, and can affect the healing of leg skin ulcers."

Where parents are not able to heat all the rooms in their dwelling, the education and development of the children can be affected in the same way as an overcrowded home.

Excess winter death figures published by the Office for National Statistics (ONS) show there were 36,700 excess deaths in the winter of 2008/09 and 25,400 in the winter of 2009/10. These figures are higher than in most other European and Scandinavian countries, many of which experience much lower temperatures during the winter.

A proportion of the excess winter deaths, particularly those due to respiratory disease, can be attributed to cold indoor conditions (Review of Health and Safety Risk Drivers, CLG 2007 Page 24).

www.communities.gov.uk/documents/planningandbuilding/pdf/reviewhealthsafety.pdf

The HHSRS Operating Guidance states:

> "Although there are some excess winter deaths in all age groups, it becomes significant for those in the 45+ age group. The risk increases in a roughly linear pattern up to the 85+ age group, after which there is a marked increase in risk."

As witnessed during the heat wave in Western Europe in 2003, changes to the Earth's climate appear to be increasing the risk of excess deaths during summer months caused by an excess of heat. Planning a response to the consequences of climate change will require consideration of the steps to be taken to avert such deaths in the future. For this reason, the outcome rightly refers to "excess seasonal deaths".

The CIEH believes that there are other social determinants of health for which there should be outcomes in the Outcomes Framework. Data is available and it would not be difficult to incorporate appropriate indicators for these suggested outcomes.

The CIEH is concerned that while smoking prevalence in adults is included in Domain 3, and the smoking rate of people with serious mental illness is listed in Domain 4, there is no reference to the prevalence of smoking in the under 18s. The CIEH believes that it is imperative to reduce the take up by children and their recruitment as the next generation of smokers to replace those who have died or given up.

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The CIEH is also concerned that there is insufficient focus on the contribution of alcohol usage to a range of ill health effects, and the longer term impacts of under-age drinking.

Land, water and food are not included anywhere, but all deserve to be. The detection and remediation of contaminated land is justified in part by its adverse health effects and there is a substantial burden of disease attached to unwholesome food and water.

An indicator for the remediation of contaminated land could be "the proportion of suspected contaminated land either remediated or dismissed as such".

An indicator for food and water safety could be "the number of food and water-borne disease notifications".

Other possible additional indicators include:

- Removal of Category 1 hazards[1] under the Housing Health & Safety Rating System;
- Reduction in the number empty homes;
- Reductions in food poisoning incidences;
- Reductions in rodent population/incidence of domestic property pest infestations
- Reductions in numbers of workplace deaths, serious injury and serious illness rate or the number of accidents notified under the RIDDOR[2] provisions."

A significant proportion of acute hospital admissions as a result of falls or fall injuries for over 65s arise from accidents in the home due to poor housing conditions, for example broken or rotten floorboards, uneven paving and insecure banisters. Repairing such defects may be the responsibility of a reluctant private landlord. The intervention of an EHP can ensure the repairs are carried out.

The homes of some older people need minor adaptation such as grab rails to assist with bathing or going up and down the stairs. These need to be easily available at low cost. The recent document published by the Department for Communities and Local Government, Handypersons Evaluation February 2011, shows important evidence of the value of such schemes in prevention of accidents and ill health.

1 The HHSRS incorporates two types of hazards, category 1 and category 2. Category 1 hazards are serious and by definition have an adverse effect on the health and safety of occupiers. Local housing authorities have a duty to take action to deal with such hazards.

2 Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 1995.

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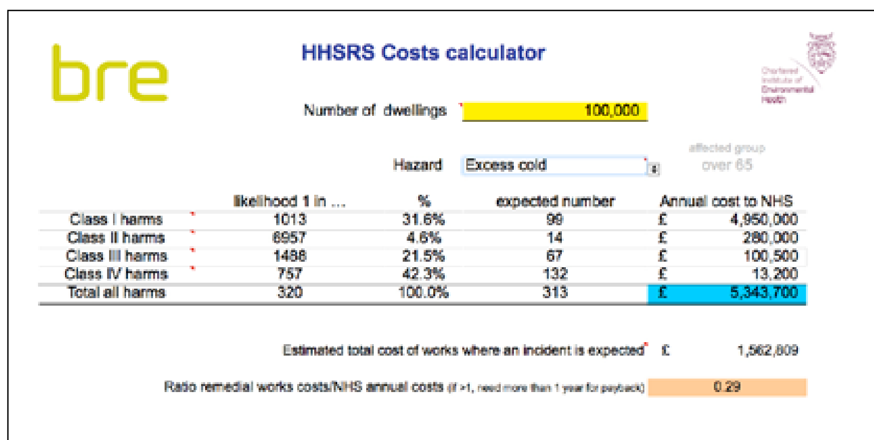
The Housing Health & Safety Rating System is well established and applied consistently across England.

In conjunction with BRE, the CIEH has developed a “cost calculator” which is capable of comparing the costs of eradicating category 1 hazards (for example excess cold) with the costs of healthcare if the hazard is not eradicated. In this way, the public health benefit of improving housing conditions is clearly demonstrated as well as the cost benefit.


bre

HHSRS Costs calculator

Number of dwellings: 100,000

Hazard: Excess cold

affected group: over 65

	likelihood 1 in ...	%	expected number	Annual cost to NHS
Class I harms	1013	31.6%	99	£ 4,950,000
Class II harms	6957	4.6%	14	£ 280,000
Class III harms	1488	21.5%	67	£ 100,500
Class IV harms	757	42.3%	132	£ 13,200
Total all harms	320	100.0%	313	£ 5,343,700

Estimated total cost of works where an incident is expected: £ 1,562,809

Ratio remedial works costs/NHS annual costs (if >1, need more than 1 year for payback): 0.29

An empty home is a waste of a valuable asset. It is also a source of a variety of environmental health dangers, including harbourage of pests, the proliferation of pest-borne diseases, opportunities for anti-social behaviour and possible injury to visitors. It is a public policy objective to reduce the incidence of empty homes and there are initiatives to support this objective, which can also address this public health outcome

Food poisoning is a serious and preventable health hazard and a substantial cost to the economy. A reduction in food poisoning incidents is a positive public health outcome. Environmental health practitioners carry out a range of interventions to raise standards of food hygiene and safety and to reduce the incidence of food poisoning.

The WHO’s LARES Survey showed that people living in rodent and insect infested premises are more likely to suffer from illnesses such as depression and migraine which would cause them to be unfit for work and on benefits. The WHO publication Public Health Significance of Urban Pests has confirmed that children are particularly at risk.

As the White Paper acknowledges, public health gains are achievable in England’s workplaces, working with and through employers and employees and employees’ representatives such as trade unions as well as self-employed workers and small businesses. Figures for deaths, serious injuries and serious work-related illnesses are readily available and reducing the rate is a positive public health outcome.

The CIEH urges the inclusion of these additional indicators in the final Outcomes Framework.

Chapter 6

Q7. Consultation question: We have stated in this document that we need to arrive at a smaller set of indicators than we have had previously. Which would you rank as the most important?

This is an exercise that ought to be evidence-led. Obviously the most useful data should lead to the highest priority for the relevant indicators. The CIEH also believes that there is scope to set key national indicators as well as a set of indicators to be used locally where relevant and which can reflect the local priorities set by the Health and Well-being Boards.

Q8. Consultation question: Are there indicators here that you think we should not include?

The process just described ought to help in coming to a conclusion in order to answer this question.

Q9. Consultation question: How can we improve indicators we have proposed here?

It will be a very welcome development if the Department achieves its ambition of amassing data that contains the information gleaned from monitoring these indicators.

As is intended, the data should be fully accessible and searchable by local public health practitioners, as well as by members of the public and public health managers and policy decision-makers.

It will clearly be essential for the data represented by the indicators to be captured, recorded and made available in ways that are (a) not overly-burdensome on those who have to supply and collate the data and (b) easy for others to access, interpret and use.

The Marmot Review found that there are many proxy indicators which can be used as indicators of whether longer term outcomes are likely to be achieved.

Q10. Consultation question: Which indicators do you think we should incentivise through the health premium? (Consultation on how the health premium will work will be through an accompanying consultation on public health finance and systems).

The CIEH appreciates the challenge for public policy regarding the tension between, on the one hand, “rewarding success”, and on the other hand supporting with the most funding the areas with the greatest need.

The Secretary of State has suggested that he would withhold this additional funding from local authorities whose public health services are not performing satisfactorily even though they desperately need support by reason of, for example, levels of deprivation or major health inequalities that may conceivably be due to factors beyond their control, for example inward migration.

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Previous work carried out by the Health Inequalities Unit demonstrates the correlation between areas of deprivation and high mortality and morbidity which means that those areas which have the worst health have the least means to address it.

Deprivation is to be accounted for in the formula for the distribution of the ring fenced grant. Even so, the CIEH feels that proven need ought to attract higher levels of funding and so the health premium ought to be linked in some way to need.

However, given the Department's stated intention to use the health premium as a tool to secure improved performance, something that seems to sit uncomfortably with the commitment to localism, consideration does need to be given to the choice of indicators to be used for measuring progress.

The CIEH tends towards an approach whereby a select few indicators are drawn together to provide a "route map" for the way forward in each locality. Rather than measuring compliance with the individual indicators, the test should be whether progress is going in the right direction as per this route map and take account of the initial baseline data for that area.

As for the choice of indicators, the recent publication by the Marmot Review Team, marking the first anniversary of *Fair Society, Healthy Lives*, reported on 5 key indicators of health inequalities and the social determinants of health. This approach may be capable of adoption for the Government's purpose, though the CIEH would commend the addition of two further indicators covering mental health (well-being) and housing conditions.

Q11. Consultation question: What do you think of the proposal to share a specific domain on preventable mortality between the NHS and Public Health Outcomes Frameworks?

As previously discussed, there are bound to be crossovers and interactions between the work of the public health service, the NHS and the work of local authorities and others in respect of adult social care.

What is important is that the outcomes for each service ought to be compatible, with outcomes and indicators common wherever possible and with compatible methodologies for the collection of and access to data.

The Health & Wellbeing Boards ought to be responsible for appraising the performances of all the services and their performances in achieving the outcomes.

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Q12. Consultation question: How well do the indicators promote a life-course approach to public health?

This approach fits with the agenda laid out by the Marmot Review's recommendations, and the CIEH welcomes it. It also fits with the Government's determination to work across a number of services and approaches to public engagement in order to change behaviour.

The CIEH supports the life-courses approach but would again emphasise that this inevitably means that some outcomes will only be achievable over the longer term and will only be effective if there is a consistent national policy over the necessary timespan.

A strengthening of messages about taking responsibility for one's own health and wellbeing is welcome.

This includes the greater emphasis on personal responsibility, the "nudge not nanny" approach and the responsibility deal. As a result, consideration needs to be given to outcomes and indicators which put responsibility on:

- Measuring individuals confidence and self-esteem, especially in the case of young people and new parents;
- Policy-makers to support this approach through public information campaigns, education, provision of services, regulation and public protection and so on; and
- Businesses to ensure that pledges made through publicly accepting the responsibility deal are then kept.

Chapter 7

Response to the funding and commissioning routes consultation paper

These public health reforms in England have to be viewed within the context of a thorough-going reform of the NHS as a whole. Whilst shifting the lead for public health at the local level from the NHS to local authorities is a major initiative, change such as abolishing primary care trusts and establishing GP commissioning consortia is even more significant.

In:

- The hand-over of existing public health services;
- The transfer of the Directors of Public Health and their staff to local authorities;
- The transition to the new service; and
- The maintenance and further development of joint working between the NHS and local authorities,

the way the Department implements this overall change in the NHS will be a decisive factor in the success or otherwise of the new public health service in England.

An overall impression the CIEH has of the proposals for funding and commissioning is that the funding is unclear and the commissioning routes are confusing.

Everyone who wants to make a success of the Government's policy for public health in England, the CIEH included, requires greater clarity as soon as possible:

- Clarity as to the total ring fenced resource that will be available for the new services;
- Clarity as to the commitment of existing budgets to support the new services, such as NHS funding from the Commissioning Board and the GPs commissioning consortia and the CLG and local authorities' funding for housing and health improving services; and
- Clarity as to the obligation of GP commissioning consortia and other funding bodies to support the Health & Wellbeing Boards' local health strategies.

Decisions made centrally will affect the prospects for success of the new services locally. Examples include Parliament's decision in respect of national-level NHS and Public Health England structures and the Department's decisions regarding the total ring fenced resource available and how it is divided up and distributed.

Chapter 7

The CIEH strongly feels that public health partners including the CIEH itself ought to have a say in, or at any rate be heard before, the making of such decisions.

The answers below give some specific responses to the particular questions being asked but this is an on-going process and the CIEH wishes to remain engaged as decisions fall to be made.

The Department's timetable for establishing the new service is ambitiously short, there is little time available for planning, deciding and implementing these reforms. It is therefore all the more critical to get these matters right first time.

It is by involving the public health partners at all stages that England has the best chance of a successful implementation of the Department's policy.

Chapter 8

Answers to the 16 questions on funding and commissioning routes

Q1 Consultation question: Is the health and wellbeing board the right place to bring together ring-fenced public health and other budgets?

Emphatically yes, and the boards should involve all the key players (including environmental health practitioners in all localities and district councils in areas with the two-tier local government structure).

The CIEH strongly argues that there should be a statutory duty on the key commissioners and providers of services, partners and others capable of influencing behaviour, such as GPs, to participate and act on the guidance provided by the local strategy published by the board (informed as it will be by the results of the Joint Strategic Needs Assessment).

This is especially desirable if the board's strategy for meeting the needs identified through the JSNA process is going to be credible and decisive in improving public health and reducing health inequalities.

Q2 Consultation question: What mechanisms would best enable local authorities to utilise voluntary and independent sector capacity to support health improvement plans? What can be done to ensure the widest possible range of providers are supported to play a full part in providing health and wellbeing services and minimise barriers to such involvement?

The Department appreciates the challenge in areas of England where there is a two-tier local government structure, but there is no specific consultation question about the ways of meeting this challenge.

It might be helpful therefore if this challenge is addressed at this point because the upper tier authorities will have to work with district councils just as much (if not more so in fact) as with voluntary and independent sector providers.

Some argue that the ring fenced funding should extend to include health improvement services delivered by district councils. Some argue that the Environmental Health function in district councils will have to be transferred up to the upper tier authorities.

The CIEH believes that these arguments can be avoided by putting in place arrangements to ensure that there is effective collaboration between county and district councils in two-tier areas.

Chapter 8

The CIEH believes that to achieve this, what is required is:

- A statutory duty for all the participants in the local public health services to support the service and co-operate with the other participants – there are precedents in the Civil Contingencies Act and for safeguarding children (Children Act 2004);
- A range of local arrangements from joint agreements to shared services and local authority consortia.

We are already seeing across England innovative approaches to the provision of local government services and wider public health services through joint agreements, shared services and co-location.

The CIEH believes that these approaches, if backed by appropriate statutory duties for working together, offer a flexible way of enabling today's local government structures to work effectively for the new public health service.

There is no reason why a similar flexible approach cannot be adopted towards voluntary and independent sector providers by all local authorities, not just those in two-tier areas.

Q3 Consultation question: How can we best ensure that NHS commissioning is underpinned by the necessary public health advice?

Reading the consultation document there is a sense of very confusing lines of decision-making and accountability when it comes to funding the new public health service. It is essential that, in response to this consultation and the responses received, the Department is able to clarify the policy and funding issues that will enable the new service to be established successfully.

The CIEH argues that there should be a Chief Environmental Health Officer for England who should be in a position to influence the decisions of national bodies like Public Health England and the NHS Commissioning Board. Such a position will support the bringing together and co-ordination of multi-agency strategies and interventions.

The CIEH also argues that Public Health England should have some kind of service users' forum and the CIEH should be represented on the forum. The CIEH is not the only valuable voice that should be heard by those making the decisions that will affect the success of the new public health service and the CIEH wants to work alongside other groups representing public health, consumers and the public generally.

It is to be hoped that Public Health England will establish itself as an authoritative body from the outset. The sources of information and advice proposed by the Department will provide Public Health England with a range of evidence.

Applying this evidence, and giving advice, Public Health England ought to make the case for improved, effective public health services across all Government Departments, NHS, local authorities and all the other participants in the new service in England.

Chapter 8

Q4 Consultation question: Is there a case for Public Health England to have greater flexibility in future on commissioning services currently provided through the GP contract, and if so how might this be achieved?

It is obvious that the role of GPs is going to change enormously, not just because of the new NHS commissioning arrangements proposed by the Department but also because public health services will become much more of a responsibility for GPs.

The training of GPs to fulfil this role will become vitally important.

It follows that the GP contract is going to need revision. In that revision, the public health consequences must be at the forefront of the minds of the negotiators, especially those negotiating on behalf of the Department of Health.

Q5 Consultation question: Are there any additional positive or negative impacts of our proposals that are not described in the equality impact assessment and that we should take account of when developing the policy?

The CIEH is especially concerned to argue that housing conditions affect health and that the new public health service must focus on ensuring that everyone has a safe, secure and affordable home.

Conditions such as insecure (or no) housing, poverty, lack of employment and indebtedness put immense pressure on people's physical and mental health and wellbeing.

The CIEH will want to see more powerful messages about tackling mental illness and promoting emotional wellbeing in the eventual brief for the new service. This will require inter-Departmental involvement.

Q6 Consultation question: Do you agree that the public health budget should be responsible for funding the remaining functions and services in the areas listed in the second column of Table A?

The second column is actually headed "Proposed activity to be funded from the new public health budget (provided across all sectors including the NHS)".

So this is a confusing question because it implies that the source of funding for all this work (a full list of public health activities) will be the ring fenced public health budget whereas elsewhere the White Paper and this consultation document stress that the NHS will go on paying for much public health activity.

The CIEH therefore asks for greater clarity in respect of the assurance given, and therefore the expectation of what the NHS will fund in respect of the public health service in England.

Chapter 8

Q7 Consultation question: Do you consider the proposed primary routes for commissioning of public health funded activity (the third column) to be the best way to: (a) ensure the best possible outcomes for the population as a whole, including the most vulnerable; and (b) reduce avoidable inequalities in health between population groups and communities? If not, what would work better?

Some attention is needed to simplify the commissioning and funding routes for crucial national public health measures like screening and immunisation programmes but otherwise the main consideration is the balance of responsibilities between Public Health England and local authorities.

Some of this needs to be trialled to see where the right balance is. Overall, issues about where to place responsibility for commissioning and funding services should not detract from consideration of the adequacy of the overall funding for the public health service.

Q8 Consultation question: Which services should be mandatory for local authorities to provide or commission?

This question highlights another challenge drawing the right balance between localism and achieving consistency through central direction.

There is going to be a statutory duty on local authorities to take steps to improve the health of their population.

The legislation should, in the CIEH's view, attach great significance to the JSNA, the role of the health and wellbeing boards and the boards' strategy statement. The onus should be on local authorities to play their part to the full in the JSNA and the boards and to support their activities, decisions and recommendations through their service delivery.

Arguably, the pre-eminence of the JSNA and the boards' strategy will mean that local needs and local priorities are reflected fully, so it is difficult to understand any need for much more in the way of mandatory services nationally-imposed on local authorities.

Q9 Consultation question: Which essential conditions should be placed on the grant to ensure the successful transition of responsibility for public health to local authorities?

The transition will be a very sensitive time. One only has to think of the potentially devastating effects of a sudden incidence of pandemic flu, a major case of infection or contamination or some other major public protection incident.

It is essential that all partners are focused on such risks during the transition. Planning for the transition is an immediate top priority. It is vital that there is clarity in public health responsibilities. It should also be a crucial objective that existing capacity is not lost.

Chapter 8

The CIEH is concerned that the public spending cuts imposed on local authorities will reduce their focus on, and their ability to maintain, existing health protection and health improvement services. Key trained and competent staff are being lost before the new arrangements come into effect. Similar concerns are being expressed in the NHS.

During the transition, it is important that the public health funding is adequate but it is also important that others are not allowed to withdraw existing sources of funding or reduce existing services, not least GP practices and hospitals.

It is also vital that the skills, knowledge and know-how of the soon-to-be abolished PCTs and SHAs are preserved and handed on to the successor organisations (in some cases it is not yet clear enough who or what is the right successor organisation to hand on to).

Q10 Consultation question: Which approaches to developing an allocation formula should we ask ACRA to consider?

Three general approaches are put forward in the consultation document: "utilisation" based on current levels of public health activity; "cost effectiveness" based on potential gains in health outcomes (biggest bang for bucks); and "population health measures" based on spending the money in the greatest areas of need.

The last of these would attract more money based on need, but it would be possible as well, or as an alternative, to adopt other existing measures of deprivation and weight allocations accordingly.

In reality, it would be de-stabilising if there were too great a break from existing patterns of spend and presumably the Department will want to dampen the effect of big winners and losers in some way.

As already stated, the CIEH is concerned that the overall adequacy of the totality of the budget should be sufficient. In other words, the cake has to be big enough for it to be divided up in meaningful slices.

Q11 Consultation question: Which approach should we take to pace-of-change?

Of course the CIEH supports the aim of a radical step-change for the better in England's performance improving public health, but the warning already sounded about the dangers during transition applies with additional force when considering the pace of change.

There is considerable turmoil currently because of the effects of spending cuts in local government and spending restrictions in the NHS. It is going to be important to resolve the issues raised in the White Paper and the two consultation documents as quickly as possible, consistent with a meaningfully participatory approach to decision-making.

Chapter 8

The CIEH would welcome being involved in the oversight of the reforms, the establishment of the new public health service in England and the provision of professional and unbiased advice.

Q12 Consultation question: Who should be represented in the group developing the formula?

The Department should draw on the expertise that already exists in respect of local government financing as well as including representation of the wider interests of public health and NHS organisations.

The CIEH is willing to be involved. There ought to be places for academia and the general public, too.

Q13 Consultation question: Which factors do we need to consider when considering how to apply elements of the Public Health Outcomes Framework to the health premium?

As already stated, the CIEH has a negative view of tying the health premium to measurement of performance as represented by individual indicators.

A better approach is to use some indicators to create a performance chart from which it would be clear whether or not a locality is moving in the right direction or the wrong direction and the relative improvement against the baseline position.

There was a useful approach taken under the previous administration in the form of National Support Teams which undertook detailed investigation of performance and supported improvement through the promotion of evidence-based practice and first-hand experience of what works.

This approach could be linked to incentives such as the offer of the health premium to reward improved performance.

Q14 Consultation question: How should we design the health premium to ensure that it incentivises reductions in inequalities?

The CIEH would much prefer language about meeting needs and not so explicitly tying funding to meeting specific measures. Funding is going to be tight and every penny of resource is going to be needed.

It is legitimate for the funder to express a wish to use funding to incentivise good practice, but populations in greatest need ought not to be penalised because a service is under-performing in their locality.

Chapter 8

Q15 Consultation question: Would linking access to growth in health improvement budgets to progress on elements of the Public Health Outcomes Framework provide an effective incentive mechanism?

This seems to the CIEH to be a worse, blunter instrument of control than the application of the proposed health premium. Given that it is likely that the relative needs of localities will be reflected in the formula by which this funding will be allocated, it seems doubly unfair to contemplate taking away some of this funding for under-performance of local services.

Q16 Consultation question: What are the key issues the group developing the formula will need to consider?

Fairness in the allocation of scarce resources has to be the top consideration.

Looking at all the evidence, including the findings of the Marmot review and the other available research findings, it is fair to match resources for public health services to the needs of populations, with the greatest resource going to the areas where the populations have the greatest needs.

Chapter 9

About the Chartered Institute of Environmental Health

The CIEH is the professional organisation for all environmental health practitioners in England, Northern Ireland and Wales. In addition it has a member region in Scotland. Currently there are over 10,500 members.

The CIEH is a registered charity and has a Royal Charter. Its mission is to promote effective environmental health practice.

The CIEH sets the educational and entry criteria for environmental health practitioners, sets professional standards including the requirement of continuing professional development and is the self-regulator for the profession.

The CIEH is additionally an awarding body and also therefore meets its charitable and Charter obligations through education and training extending well beyond members of the profession. Every year the CIEH awards around half a million qualifications in subjects such as food, health & safety, fire safety, first aid and environmental and sustainable management.

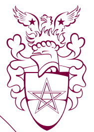
The CIEH has its roots in environmental and public health practice dating back over 120 years:

Relevant in the past – effective in the delivery of drains, drinking water and disease-eradication in the 19th century as well as the great slum clearances and clean air programmes of the 20th.

Relevant in the present – effective in carrying out statutory duties of port health safety, health protection - ensuring compliance with health safety laws such as food hygiene and smoke free public and work places - and working with communities and other partners to promote health improvement.

Relevant in the future – effective in the growing public health agenda, especially helping to address the social determinants of health, and anticipating the changing health threats associated with societal change and climate change such as pandemics, new pest and vector borne diseases and excesses of both cold and heat.

With a broad membership engaged in the public and private sectors as well as agencies and voluntary and not for profit organisations, the CIEH has immense experience and capability in all aspects of environmental health, and it is completely relevant to the proposed new public health service in England.



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