Chartered Institute of Environmental Health

Public Health Series

Healthy Lives, Healthy People: Towards a workforce strategy for the public health system

Response to the Government's consultation

by the Chartered Institute of Environmental Health

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Chapter 1

Summary

The CIEH has consistently supported the Government's ambition of improving England's public health performance and sees the Health & Social Care Act 2012 as providing the means of achieving this ambition more expeditiously.

The recognition in the report of the Marmot Review *Fair Society, Healthy Lives* of the wider determinants of health and wellbeing, and particularly the 'life-stages' approach to tackling health inequalities is welcome. So too is the Government's stated intention of achieving a step-change in England's performance in bringing about improvements in the health and wellbeing of the population as a whole. This central premise is clearly articulated in the 'vision' set out in the Public Health Outcomes Framework - to improve and protect the nation's health and wellbeing, and improve the health of the poorest fastest.

In a previous response to the Department of Health's (DH) consultation on the White Paper *Healthy Lives, Healthy People*, the CIEH focused on how it saw success flowing from the Government's public health policy. The development of an effective and enduring public health workforce strategy is something that the CIEH supports and would want to help to shape. However, as the following responses to the current consultation show, we do not think that the strategy as it is currently drafted is 'fit for purpose'.

In this response, the CIEH addresses the 17 questions posed by the DH in its consultation draft, and also comments on the appropriateness of the structure of the draft workforce strategy. However, in our opinion, rather more work is needed (the consultation document appears to acknowledge this) and this cannot come soon enough, given the very tight deadlines that fall early in 2013. Consequently, the CIEH would wish to remain fully engaged in the process and so help fashion an effective strategy.

We would expect the eventual workforce development strategy to articulate the balance of skills and competences that are needed within the workforce to enable it to deliver the Government's public health objectives. The strategy will need to have regard to the breadth of current thinking on the skills make-up of the workforce. This should be supplemented where necessary with a skills audit, which will allow deficiencies to be identified and remedied.

Of considerable surprise and concern to the CIEH is the extent to which the Public Health Skills and Careers Framework (Cube) is disregarded within this consultation. Whilst the consultation makes reference to the need for *defined career development pathways* in public health, it almost completely ignores the Cube and what it has to offer as a way forward in this respect. We wish to point out that the CIEH was an active participant in the development of the Cube and has promoted it widely as a means to encourage our members and others to identify their transferable skills in planning their careers.

The CIEH believes that the environmental health component of the workforce already meets many of the Government's stated aspirations for delivering community-focused public health via a process of facilitation and empowerment. In addition, it is able to utilise its regulatory powers where persuasion and education fail.

This response also looks at the qualities of the environmental health workforce, its skills and competences and the model that it follows to deliver key public health outcomes in a practice-led environment. It specifically looks at environmental health as the only dedicated professional element of the local government workforce, drawing upon its experience of delivering public health services since the very dawn of the modern epoch. In particular it draws attention to its present-day contribution to health protection, promotion and improvement and its proven capacity to deliver public health in the communities where people live, work and co-exist.

The Public Health Minister has described Environmental Health Practitioners as 'The Guardians of Public Health'. We believe therefore that it is self evident that environmental health will constitute a key element of the support needed by Directors of Public Health in carrying out their extended remit.

Finally, we will expand upon our concern that this consultation document makes no reference to the very considerable disparity that exists between the NHS and local government in terms of funding for the development of the existing public health workforce. It is manifestly clear that the NHS has considerable funding at its disposal for assisting its staff in their career development and support, whereas local government has not been allocated a budget to support the environmental health profession.

The tradition may have always been to expect local authorities to fund human resource development for public health through Masters-level study and CPD as it would do any other service. However, with the Exchequer expecting cuts of 28% over the four years leading up to the implementation of the Health & Social Care Act in 2013, it seems quite inappropriate and most unjust not to extend funding across the field.

Chapter 2

The CIEH's vision

The CIEH believes, as does the Government, that it is important that we protect and improve the nation's health and wellbeing. It is also important to us that we improve the health of the poorest and most vulnerable in society the soonest. The achievement of this goal demands a step-change improvement in performance at every level of society.

The CIEH believes that it is right that local authorities lead England's public health service locally because they have democratic legitimacy, are accountable to local communities and play a unique role in community leadership. As a result of their connection to their local community, they are also more readily aware of the needs of the communities that they serve.

In this respect, the CIEH stands foursquare behind the findings and recommendations of the report of the Marmot Review: *Fair Society, Healthy Lives* and those of The Wanless Report: *Securing good health for the whole population.*

As a result of the profession's long history in delivering a social policy-led public health service, the CIEH believes that in the interests of disease prevention and the enhancement of wellbeing, this should be developed and implemented as close as possible to the communities that public health purports to serve. Only in this way will it be possible to tackle the wider determinants of poor health and wellbeing in parallel with the national, population-level, strategies that seek to address the 'causes of the causes'.

In this pursuit, the CIEH commends the capability of Environmental Health Practitioners (EHPs) to act as advocates for health as well as the competencies of EHPs to deliver high standards of public health practice within their communities.

In supporting the role of EHPs in community action, the CIEH believes that it is essential, for reasons of social justice, for us to tackle health inequalities that are created through wider economic, environmental and social factors. To do this effectively, we need to effect behaviour change through techniques which empower individuals and communities to take greater responsibility for their own health and wellbeing.

The CIEH further believes that for EHPs and communities to succeed in securing and improving the public's health and wellbeing, a multi-disciplinary public health workforce is necessary to work with and within communities. This multi-disciplinary approach, which EHPs routinely adopt, is at the heart of bringing about the step-change improvement required and to achieving the outcomes set out for England's new public health service in the Public Health Outcomes Framework.

To be successful this public health workforce needs to work holistically, and in partnership with others, both professional and lay, something that Marmot prizes highly in terms of effectiveness, recognising that local delivery '...*requires effective participatory decision-making at local level...and can only happen by empowering individuals and local communities*

Whilst the DH consultation draft and our response to it relates to a public health service for England, the CIEH is mindful that there are lessons that might usefully be learned from public health experiences in other parts of the UK and beyond. Let us hope (though better we make this hope our intention) that in developing a model for the delivery of a public health service fitted for the 21st Century, that the practice that this sets in train here in England may also be an inspiration and guide to others.

Chapter 3

The CIEH's views in response to the issues raised by *Healthy Lives, Healthy People: Towards a workforce strategy for the public health system*

1. Environmental health's place in public health

Historically, the environmental health profession and its practitioners have been at the heart of many community-focused pubic health interventions that have shaped modern society. Successes in sanitation, housing regeneration, clean air, food safety and, more recently, achieving smokefree indoor environments are notable amongst these.

The then Chief Medical Officer's analysis of the public health workforce in 2001 noted that the Environmental Health Officer was the only local government professional considered to be a full-time public health practitioner, evidenced in his description of the environmental health practitioner as: '*Professionals who spend a major part, or all of their time, in public health practice*'.[1]

Their professional competence in public health is played out through their technical work in food safety, occupational health, housing and environmental protection, but this is invariably and explicitly focused on the means available to protect, improve and promote better health and enhanced wellbeing.

This combination of health focus, technical competence and accessibility makes today's Environmental Health Practitioner (EHP) a key professional in the public health workforce, whether acting alone or in partnership and in local government or private practice.

The 'Synopsis' which sets out the learning outcomes, practice skills and core competencies behind the qualification, provides some detail about what it is we expect EHPs to do, but in conceiving this as a curriculum (currently 'Curriculum 2011') we would identify the following characteristics as some of their strengths:

- capable of taking control of complex situations and making rational, risk-based, decisions without fuss and self-aggrandizement;
- capable of using highly-regarded problem-solving skills to good effect in many different settings, in both the public and private sector;
- possessed of abilities and strength of purpose to challenge the orthodoxy of 'public ill-health' and so truly 'advocate' for health;
- freely and openly acting as the health professional on hand to communicate with people on health and well-being, constantly checking that messages are understood; and,
- caring and empathic, where concern for the health and welfare of others occupies both their personal and professional conscience.

[1] The Report of the Chief Medical Officer's Project to Strengthen the Public Health Function **http://tinyurl.com/73xl94u**

2. Health protection, resilience and emergency preparedness

EHPs can demonstrate practice across all domains of public health, however one of their most critical inputs is in health protection. Working with Directors of Public Health and their teams and with the Health Protection Agency's health protection units, EHPs work constantly to protect people from harm and act quickly and decisively to minimise health risks that arise from a range of both chronic and acute environmental stressors.

They also have a key role in the event of more imminent threats such as pandemic flu, E.coli and food-borne disease outbreaks or Legionnaires' disease.

There is no certainty that England will be free from such threats during the transition to the new public health service. The health protection contribution of EHPs working in all communities will be particularly significant during this time.

3. Multi-disciplinary services

Working across the public, private, and voluntary sectors, EHPs are experienced in and committed to multi-disciplinary working where they contribute a range of special skills to the partnerships in which they are engaged. In local authorities, they work in an environment where multi-disciplinary working is mainstream and good practice abounds. Some examples of environmental health practice delivering key public health outcomes are set out in the CIEH's publication *Our health, our wellbeing*[2], a copy of which accompanies this submission.

Rather than being confined to attendance upon a medical model of public health practice, environmental health works to a broader, social model of public health practice. In their widely recognised work, *Dahlgren and Whitehead* set the agenda for understanding the scope, boundary, or the "realm" of a social model of public health practice; their seminal work was taken further by *Barton and Grant* in 2006 and their adaptation of Dahlgren and Whitehead's model which is presented below.

[2] http://www.cieh.org/WorkArea/showcontent.aspx?id=42440

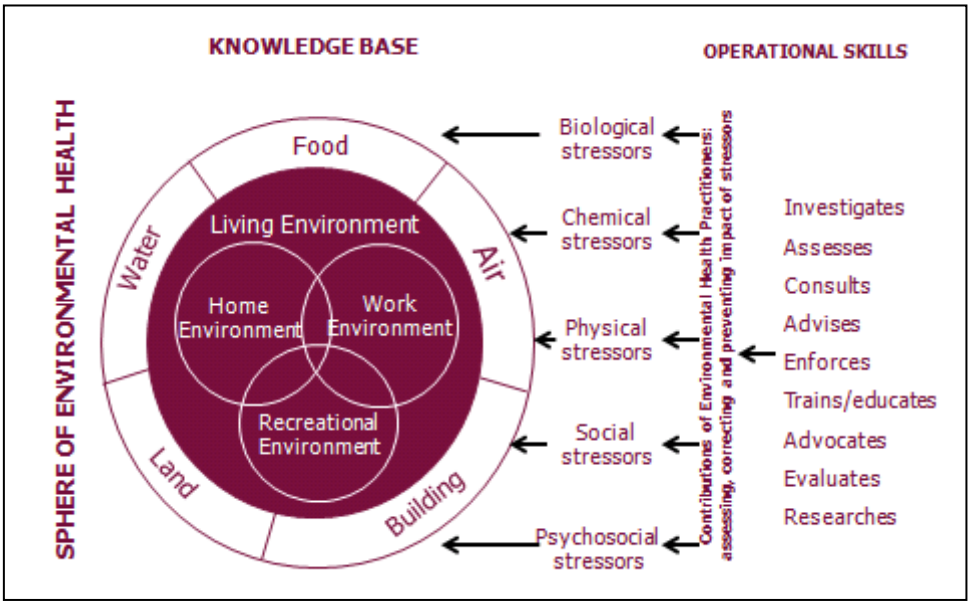
Source: Dahlgren and M. Whitbread (1992) Policies and strategies to promote social Equity and health Copenhagen: World Health Organization

This model of practice identifies a range of determinants of health and well-being within our communities, and EHPs working across our communities in partnership with other public health practitioners have important roles in addressing the 'causes of the causes' of our health and well-being.

A more tightly defined explanation of the environmental health contribution to public health can perhaps be found in the formal model developed by *Burke et al after McArthur and Bonnefoy*[2] This model sees our world divided up into a number of realms that include the home, work and recreational environments. In these environments are to be found aspects of our lives that are of direct relevance to public health practice and practitioners. These aspects include land, buildings, water, air and food and, together, these aspects and environments are directly affected by a range of stressors that include those of biological, chemical, physical, social and psycho-social origin.

The model, detailed below, identifies that EHPs, working as part of a multi-disciplinary team, can assess, prevent, correct or mitigate the impacts that these stressors develop within our world.

McArthur and Bonnefoy's model of environmental health delivery



EHPs have always worked as part of a multi-disciplinary public health workforce. However, in 2011 the CIEH made significant changes to the systems and processes surrounding the education and professional development of its practitioners to ensure that they remain fit for purpose and capable of fulfilling a key role in the public health workforce.

Specifically, the CIEH strengthened the qualification programme for EHPs to ensure that contemporary public health skills are embedded within all practitioners and that such skills, with the exception of those associated with the commissioning of services, are fully aligned with those set out in the consultation document.

A copy of the CIEH 2011 Education Framework and Curriculum accompanies this submission.

Furthermore, the CIEH is currently working with the UK Public Health Register to ensure that, as soon as possible, newly-qualified EHPs will be eligible for voluntary public health practitioner registration on the UK Public Health Register.

In terms of public health education, training and support for all EHPs, the CIEH has reached a position where:

1. A visionary framework document underpins all that we do[3]
2. The education curriculum is fit for purpose
3. Compulsory Continuing Professional Development ensures that knowledge is kept up to date and skills remain contemporary
4. The CIEH is focused on providing ongoing guidance and support.

The CIEH has now turned its attention to the introduction of a scheme for practitioner revalidation which it is intended will be applied in the case of all EHPs.

[3] Environmental Health 2012 - A key partner in delivering the public health agenda

4. Statutory regulation of the public health workforce

Throughout the development of the Government's plans for England's new public health service the CIEH has urged caution with regard to decisions around registration and regulation of the workforce. This is partly because there is still so much uncertainty about a number of key issues concerning the new service.

It has been disconcerting to observe the Government, whose policy in general is to prefer voluntary schemes to statutory compulsion in this regard, succumb to calls for statutory regulation before resolving those uncertainties.

Currently, the language suggests that statutory regulation will apply to the small sub-set of the public health workforce which comes under the heading of 'specialist' or consultant. Some existing members of this group are medical practitioners who are already subject to statutory regulation. Others come from disciplines that are currently included on the voluntary UK Public Health Register having achieved eligibility either through completing the Faculty of Public Health's 5 year course or via the portfolio route.

Those who have put forward statutory regulation for immediate adoption have suggested that the Health Professions Council will be the appropriate registering and regulating body. This unequivocally 'medical model' of regulation sits uneasily with assurances of a multi-disciplinary workforce.

It seems odd not to invest some time and attention in an examination of the UK Public Health Register as a vehicle for registration and regulation going forwards. For a Government that espouses the voluntary before the statutory solution, it is bizarre that a voluntary option might not be allowed – not even in coexistence with other routes to registration and regulation. Furthermore, as a UK-wide register, there are implications for public health practice in other parts of the UK if England takes action that puts the future existence of the register in jeopardy.

The UK Public Health Register has recently developed the offer of voluntary registration for practitioners. The pilots of this conducted in Kent, Wales and West Midlands have, by all accounts, been very successful. To the CIEH, there is an exciting prospect opening up of a variety of professionals choosing a career in public health and to make their career 'journey' from 'practitioner' to 'specialist' along a course that always permits registration on the UK Public Health Register.

5. Translators, interpreters and guides

NHS staff often express concerns to the CIEH that people in local government appear to 'talk a different language'. Conversely, those in local authorities make the same observation about their NHS colleagues. There is no doubt that there are very real differences in the cultures, systems, working practices and lines of accountability in the two organisations.

There is a need for a unifying approach and EHPs can be expected to be adept at providing this since, although they may have worked for a long time in local government, yet they will have had regular dealings with NHS organisations and their staff in a wide range of settings including health improvement and health protection partnership working.

6. Workplace wellbeing and SMEs

Dame Carol Black's work on wellbeing in workplaces inspires us all to take the public health messages about good health and wellbeing to workplaces everywhere. Indeed, workplaces are ideal settings for the new public health service to focus its early attention because they enable very large audiences to be reached. There is also something of a head start for delivering these messages because of the settled occupational safety and health culture that already exists.

Many CIEH members work in senior positions of private businesses including many of the well known national and international companies, especially those involved in food production, catering and retailing. They also have highly influential roles in providing occupational safety and health services and advice for employers. Others are local authority Environmental Health Officers and other regulatory officers who visit employers, especially the two million or so small and medium sized enterprises, to encourage (and sometimes to enforce) compliance with requirements of the law.

These existing entries into engagement with businesses of all sizes ought to be grasped as soon as possible. Who else but those local authority inspectors offer on-going relationship building around this new, more positive public health agenda? Furthermore, support to local businesses is an important contributor to economic regeneration and EHPs support business growth and the maintenance of a level playing field.

Many business managers understand that securing high standards of workforce health and wellbeing makes good business sense. Fewer sickness absences and a happy and settled team make for a more productive enterprise. EHPs can support businesses in this work which in turn means supporting growth in the economy and jobs.

7. Examples of public health impacts and innovative practice in environmental health

Contained at appendix 1 to this response are three examples of positive public health impacts achieved in an environmental health context to practically illustrate the points made above.

- Improving housing conditions in the private rented sector
- Healthier Menu Choices for Children when Eating Out
- Bristol's home action zone

Chapter 5

Answers to the 17 questions

In this chapter, we use the abbreviation 'EHP' to refer to an Environmental Health Practitioner, which is a protected title.

Question 1 (Para 1.7):
Do you agree that a public health workforce strategy should be reviewed regularly? If so, should this be every three years or every five years?

A useful workforce strategy is one which is reviewed regularly. Five years is preferred to three. Any timetable for programmed reviews should be sufficiently flexible to allow a review to be skipped if there is no immediate need for it or brought forward if circumstances, for example where significant changes have occurred, require an earlier review.

It should also be borne in mind that there is normally a four year cycle for curriculum changes to take effect and similar time can be needed to embed changes in training and practice for the existing workforce.

Question 2 (Para 2.5):
Are these four groups a useful way of describing the public health workforces?

The consultation does not clearly explain the purpose of the proposed classification of the public health workforce (three broad categories, four broad groupings). Had it done so, it ought to have recognised that there may be different purposes – and that the classification might be different depending on those purposes. As it is, the classification proposed is inadequate because it does not fit with the reality in practice. For example, professionals practising in environmental health, housing, planning and transport (to take but a few examples) contribute to public health outcomes as strategic leaders, directors of services and providers/commissioners of services in all or much of the work they do.

In 2001 a former Chief Medical Officer described three categories of the public health workforce slightly differently:

1. Public health consultants and specialists
2. A number of professionals who spend a major part, or all of their time, in public health practice including for example environmental health officers engaged in health protection work
3. "Most people, including managers", who have a role in health improvement and reducing inequalities, although they may not have recognised this.[4]

What is interesting about this different formulation is the greater emphasis on the professionalism of the body of the public health workforce. The CIEH argues that the specialist/practitioner division is too simplistic and that a multi-disciplinary workforce at all levels of the public health workforce is essential.
The quality assurance of the public health workforce is not best achieved by extending existing models of statutory regulation of medical professions to cover non-medical specialists.

[4] The Report of the Chief Medical Officer's Project to Strengthen the Public Health Function, 2001 **http://tinyurl.com/73xl94u**

One significant aspect of this clearer emphasis on the professionalism of the workforce is that it fits with the Government's stated intention of devolving more power to, and trusting the judgement of, professionals.

As it is, the classifications adhere too closely to an overly medically-oriented model of public health. The groupings need to be more explicitly multi-disciplinary, and the holistic nature of much of the work ought to be reflected in the groupings. There is a clear role for the various professional bodies in assisting with this approach.

This point applies with as much force at the consultant/specialist level as it does at other levels of involvement in the public health workforce, because diverse contributions are made by way of strategic leadership, healthcare services delivery, nursing and community interventions.

It is disappointing that Table 1 only refers to 'environmental health officers' as practitioners who carry out **some** public health work. The CIEH argues that EHPs are the only health professionals in the local government workforce who have public health functions and interventions absolutely central to their work and in which they are engaged throughout each and every working day. Without question, EHPs are capable of delivering public health interventions in the new structures being created in local authorities for the delivery of the new public health service.

EHPs, as the main professional public health workforce in local authorities, have the proven ability to influence public health outcomes and a remarkable 'track record' of doing so across the entire history of the modern discipline. The CIEH has published a compendium of case studies containing examples of their public health work called *Our health, our wellbeing*.[5] The CIEH can help its members by continuing to promote public health career pathways and by being more supportive of the career progression of EHPs in the public health workforce. There should be no 'glass ceiling' on this progression.

If Advisory Appointment Committees are to remain for senior public health appointments then the composition of the appointment committees should be adjusted to reflect wider interests of local authorities, including environmental health. Local authority representatives have been attending appointment meetings for posts involving duties in relations to local authorities for many years and now that most posts will be in local authorities it is clearly time to formalise this involvement.

Question 3 (Para 2.12):
Do you agree that methods of enumeration of the public health consultant and practitioner workforces should be scoped and piloted at a national level? Or do you think that workforce planning can take place effectively at a more local level eg LETBs working with local partners?

Workforce planning – from horizon scanning at one end of the spectrum to delivery of education and training at the other – is essential. The consultation does not address this range of planning directly. As regards enumeration (which the CIEH takes to mean the establishment of **numbers** in order to move to the remainder of the planning process) there may be merit in distinguishing between consultants/specialists and the remainder of the public health workforce. The former, being small and specialised, may benefit from national attention whereas for the majority of the workforce, local issues and needs will influence its distribution and planning.

[5] http://www.cieh.org/WorkArea/showcontent.aspx?id=42440

A single national system for enumeration of a practitioner workforce would not allow for the considerable local variation that exists (for example as between rural and urban areas). It is clearly a significant concern that the local government environmental health workforce is largely located in district councils where there will be significant contributions to be made to localism, local determination, community engagement, contributing to the JSNA and public health strategies. It is also important to take account of the Port Health Authorities with their discrete functions and vital work of public protection for all communities. Local systems, therefore, for the practitioner workforce are preferred. However, they would need to involve more than the LETBs, which are new, largely unknown and, it would appear, unconnected to local authorities.

These diverse systems could be supported by partnership arrangements involving a number of organisations including professional bodies like the CIEH in a range of functions from enumeration to training activity. These activities will depend on the availability of **adequate** funding. **Levels** of funding will differ, especially if local authorities are expected to contribute from their ring-fenced grants (because the formula will result in differential distribution).

Question 4 (Para 3.7):
Would these values, combined with the features of public health in Box 2, serve to bind together dispersed public health workforces?

No, the features of contemporary public health, principles and values set out in the consultation are inadequate to describe what should bind the public health workforce together.

The Box 2 features of contemporary public health is too academic and not sufficiently in line with current practice. For example, population based interventions involve extensive community engagement and work with communities, work which is already undertaken by local authorities, including environmental health.

The features of this box need to be developed in order to capture other essences of public health practice, including the Marmot emphasis on community empowerment, addressing the 'causes of the causes' through a 'life stages' approach and the social justice that demands that we work to reduce health inequalities.

What is described is clearly too heavily reliant on medical models of working, most clearly demonstrated in the emphasis on the individual (patient's) rights in the four biomedical principles referred to. There ought, at the very least, to be an acknowledgement of the clash between individual rights and community action – for example as set out in the "ladder of interventions" approach to decision-making with regard to interventions that may range from completely respecting the individual's choice to regulating to eliminate such choice. Community-wide interventions such as immunisation programmes and smokefree workplaces and public places demonstrate instances where wider community benefits may trump the rights of individuals.

It is worth pointing out also that words like 'beneficence' and 'non-maleficence' are not in every day use and ought to be replaced with terms that embody the principle of plain English.

There is a need to match these principles and values to the professional competences which members of the workforce will have to demonstrate. The issue of competence is addressed later in this response.

Question 5 (Para 3.14):
What further actions would enhance recruitment and retention of truly representative public health workforces?

The public health workforce should be multi-disciplinary at every level of its organisation and in every way that it works. This will allow for "cross-pollination" between different disciplines and reduce the tendency to work in silos.

Where local authorities may be less effective is in mapping career pathways and so this is an area where local government elements of the public health workforce might learn from their NHS colleagues. However, what is called for is a wider base with more opportunities for progression. The Public Health Skills and Careers Framework ("the Cube") takes this approach but it is in need of updating in order to fit with the new public health landscape.

There have been pilots of voluntary registration of public health practitioners in Kent, Wales and the West Midlands and these pilots have been very successful. There is good learning to be had from these pilots for the future public health workforce.

The public health workforce should be reflective of the communities served. Local authorities provide a good role model already in this respect and their staff have knowledge and skills to share with public health colleagues.

The opportunity should be taken to tackle head-on the two cultures of local government and the NHS – not only for staff transferring between organisations, but for all staff working across the organisations. There is a need for a workforce planning tool that brings the workforce together and attracts the brightest and the best into public health careers. Students and all those in training should be encouraged into this workforce for work experience, placements and recruitment.

Reorganisations often lead to a loss of good people with skill and talent and this reorganisation of public health in England is exhibiting serious signs of such losses from both NHS organisations, such as primary care trusts, and local authorities. Staff morale in public health is reported to be low as a result and there is much to do to mend both skills gaps that have opened up and motivation for existing staff.

Question 6 (Para 3.25):
Are there workforce challenges and opportunities we have not identified? What support could be put in place to help meet these challenges?

The Government's over-arching ambition for England's new public health service ought to feature strongly here. As regards threats, the political reality of joining together different professions and organisational cultures is a major challenge.

The consultation document identifies three major challenges for our public health service in this the 21st century, each of which we will comment on.

However, we believe that other significant challenges arise in relation to housing, resilience planning, pest control, anti social behaviour, sexually transmitted diseases and drugs. We would point out that it can be maintained that these challenges are all inter-connected and it will require multi-disciplinary approaches to tackle them.

Climate Change
We can expect pressure on health and social care budgets because of effects of, for example, poor air quality. Mitigating climate change would directly contribute to the public's health and address the budgetary pressures. Furthermore, healthy choices such as taking more exercise will reduce rates of Alzheimer's disease, depression, osteoporosis, obesity, diabetes and various cancers, as well as rates of heart attack, high blood pressure and stroke. Opportunities exist to provide services in ways that are more sustainable from both an environmental and a financial point of view

Demographic change
We can celebrate that people are living longer lives but as a result of this trend many more people are living longer with complex health and social care needs. Today's model of providing services for this rising population is not sustainable and therefore we need to develop new ways of delivering services which involve individuals and communities in the delivery of more integrated services

Obesity
The forecasted effects on health and social care services and budgets due to what is already an alarming increase in the incidence of obesity are well documented. We simply cannot carry on a "business as usual" approach to tackling the problems associated with obesity. Changing behaviour in order to address this public health threat represents an immediate and serious challenge for the new service.

Further challenges are bound to arise as the century unfolds, some of them as yet unforeseeable. It is likely that climate change, migration and shrinking natural resources will be the driving forces behind some at least of the century's emerging public health threats. This fact emphasises the importance of a competent and flexible public health workforce supported by world class (and in some cases world-wide) surveillance data and scientific support. Indeed there is a key role for research in early identification of emerging trends/threats as well as utilising data obtained from collecting evidence of interventions and their effectiveness.

More immediately, at this time of severe economic difficulty, the positive contribution to economic regeneration of combining support for business growth, public protection and public health should not be under-estimated.

Securing a strong and resilient health protection function during and beyond the transition to the new service remains a major challenge. The Government's focus, and that of the public health workforce leaders, ought to be on strengthening the frontline workforce. There ought to be support for this work from the Local Government Association, the professional bodies and national regulators such as the Environment Agency, the Food Standards Agency and the Health and Safety Executive all of whom have stakeholder interests in the delivery of public health services.

This new public health workforce has to be built up in a time of severe budget cuts and the already heavy workloads of those who are doing this public health work currently, EHPs included.

The strategy ought to make explicit the inevitable tension between achieving public health outcomes, which are in many important areas necessarily long-term, and political priorities, which are more often tied to electoral cycles. That said, there should also be consideration of how we might achieve some "quick wins" to enthuse and motivate the workforce and reassure the public.

Question 7 (Para 4.7):
How can local people be encouraged to develop their skills for public health in the new system?

Involving local people applies at several levels. At one level, public health is everyone's responsibility and there is a need to educate, encourage, empower and enable individuals to play their part – for example, support for people with long-term illness and disability to manage their conditions.

Marmot states that it is crucial to empower communities, to put local people more in control of their lives and the factors that affect their lives, and Wanless advocated the 'fully engaged' scenario in order to address the major public health issues of our times.

Together, groups of individuals comprise communities and work is needed with them to encourage participation in, and delivery of, an active public health service. This may be through recruiting and training community "champions". It may also be through recruiting voluntary groups to assist in the delivery of public health interventions using existing community assets. It is important to engage communities on their own terms, in the places and at the times of their choosing. Sometimes the timing is vital – catching the public mood in order to have good prospects of intervening successfully. EHPs are effective at this work, as the case studies in *Our health, our wellbeing* demonstrate.

Public health projects involving communities have to be planned to be sustainable and this means more than skilling-up community champions to do the work. It takes commitment by all public health partners, including funders, to ensure that sustainability is integral to the planning of the intervention. EHPs can demonstrate through their past community engagement that they can provide such support.

Identifying and utilising these **community assets**, including human resources, is a key component of the successful delivery of the new public health service. EHPs are well placed to be part of this process, for example equipping members of communities with necessary skills. An example might be – in tackling the problem of obesity - providing advice and services to members of communities as to the safe storage and cooking of food, nutritious diet and physical exercise.

EHPs and others whose work involves interaction with individuals and communities can help make a success of a **'Make every Contact Count'** approach to delivering the public health service.

EHPs can also help develop an understanding of the barriers encountered in engaging individuals and communities and developing holistic solutions to the problems identified. Achieving behaviour change is key to much of the work that EHPs carry out now – for example in addressing fuel poverty or abating noise nuisance.

Many members of the public health workforce engaged in this work, will need similar skills to those demonstrated by EHPs including skills of listening, supporting, training, evidencing outcomes and identifying what works.

Just like everyone else, communities will have to provide commissioners with evidence of effectiveness and cost-effectiveness of desired interventions.

It is also important to have regard to the significance of the various media which influence communities and through which communities receive information. Skills in engaging with different media, including social media, will be required.

Question 8 (Para 4.11):
How can the public health element of GP training and continued professional development be enhanced?

The future public health training of GPs must reflect the new arrangements. For example, the element of public health experience in training that is currently voluntary will need to become mandatory for all trainees in future. Greater use will be made in future of secondments to areas which can offer direct experience of public health interventions – for example local authorities, including in environmental health.

The ongoing professional development of existing GPs needs to be adjusted to ensure that GPs have information about the full range of public health functions and to ensure that they "think prevention" and "think community".

The GP contract needs to be amended to incentivise public health awareness, training and CPD in public health through the funding arrangements. This needs to be aligned to the Public Health Outcomes Framework.

Health protection is an important public health focus and GPs need to be more aware of their contribution and the contribution of others, including EHPs, to maintaining our health protection preparedness and resilience.

EHPs have experience of working with GPs and there have been a variety of ad-hoc arrangements over the past four decades for EHPs to be engaged in the training of doctors, particularly those intending to work in community and public health roles. Such arrangements could be reinstated and formalised. For some GPs there are cultural issues to address, for example embedding knowledge, skills and capacity to recognise where interventions to address wider determinants of health and wellbeing are needed and are available. It is just as important for GPs to "make every contact count" and make appropriate referrals to other agencies as it is for all other public health workforces.

Question 9 (Para 4.18):
Would it be helpful to describe the potential career pathways open to public health practitioner workforces?

We could maintain that the 'career pathways' already describes the opportunities that exist or will exist for EHPs who are engaged in the public health workforce.

There is a strong case to be made that EHPs once established in post <u>are</u> already engaged full-time in public health interventions and so the career pathway of a 'specialist public health practitioner' should be seen as 'realised' and not as 'potential'. In this respect the EHP might be seen as a 'specialist public health practitioner' who applies a range of intervention options to the risks encountered in various hazardous environmental settings with the express purpose of bringing about improvements to health and wellbeing

Whilst it is still true that most EHPs are employed in the early stages of their careers in local government - where the focus is on interceding through the application of regulatory control measures when people are exposed to risk in their homes, places of work and general living

environment - EHPs can also be found in every area of public and private sector health engagement.

Aside from the more 'technical' aspects of their work, EHPs are increasingly involved in local strategic planning where their skills are applied to addressing the multi-factoral, social determinants of health. A number now occupy the very highest positions in public health management at Consultant level and also as Directors of Public Health. They have also risen to the highest positions in local government as Chief Executives, Directors and Heads of Service.

In this direction we feel it to be helpful to reflect the different career pathways in context and using a framework that addresses the competences required. For this reason we believe the framework 'Cube' still serves the interests of public health well, and although it clearly needs an 'overhaul', we would call for its retention and use as we look ahead to 2013.

Professional bodies do have a role and the CIEH wishes to work with the Government, other professional bodies and other relevant organisations (for example Public Health England) to develop and promote career pathways to, from and through areas of environmental health practice.

To that end, we have actively supported the development of PHORCast (*Public Health Online Resource for Careers, Skills and Training*) since its inception and we are represented at Board level.

Question 10 (Para 5.14):
What benefits would multi-disciplinary training bring to the public health workforces?

It should be clear that the current environmental health workforce consists of a cadre of graduate health professionals who, in the process of qualification, follow a common curriculum focused on public health and undertake a prescribed period of training that develops the skills and competences necessary to practice.

This process is strictly controlled through the accreditation of universities offering BSc and MSc programmes and through the assessment of candidates by the demonstration of 'reflective learning', examination and interview. Thereafter, the commitment to the principles and practice of environmental public health is secured through the award of 'Chartered' status and thereafter maintained professionally through 'continuing professional development' and subject to self-assessment through 'competency frameworks' applied to practice.

Beyond this there is no doubt that EHPs would benefit from engaging in multi-disciplinary training, where anecdotal evidence from EHPs attending MSc Public Health and MPH/DrPH programmes alongside other professionals is most positive. With closer attention to the costs involved in attending programmes that lead to higher academic awards, a need exists for in-service training that can be accomplished over shorter periods of time, but with a strong emphasis on establishing partnerships in the 'classroom' that can be developed into inter-sectoral working practice.

In our experience this means delivering training as locally as possible.

In Eastern England multi-disciplinary training has already taken place and the participants report that it has been very successful in breaking down barriers, promoting partnership

working and ensuring more consistent messaging. There are synergies to be gained from this approach more widely.

There are benefits to be had from multi-disciplinary training, including lifting practitioners out of their silos, sharing perspectives, respect for colleagues and a common language. It will also be useful in helping to address and overcome the challenge of uniting two cultures into one and continued cross organisational working.

Conversely, there are issues that need to be addressed for these benefits to be achieved, including an understanding of the meaning of "training", for whom and at what level of delivery as well as more practical issues such as where and how training is delivered and at whose cost.

Question 11 (Para 5.24): How can LETBs best support flexible careers to build extended capacity in public health?

The consultation is not very clear on what is meant by flexible careers. EHPs would welcome the flexibility to make career progression towards the senior levels of the public health workforce based on their knowledge, skills and experiences.

At one level, the consultation suggests that this is more about growing capacity through enabling more part-time working. What the CIEH would like to see is flexibility in the recognition of the range of public health professionals, rather than the workforce groupings shown in Table 1.

For LETBs to promote and support flexible careers in public health, and thereby help increase overall capacity, it will be helpful for the composition of LETBs to be representative of the range of public health participants.

The CIEH would welcome representation on LETBs and our view is that without some non-medical representation on them, LETBS will not be considered to be able to be representative.

Question 12 (Para 5.25):
Is the healthcare Education Outcomes Framework appropriate for public health education and training? If not, how could it be adapted?

No. It is helpful for the consultation document to start a conversation about an Education Outcomes Framework, but the draft shown in the consultation document is not appropriate.

The CIEH has extensive experience of defining learning outcomes and designing systems to deliver them - it has an international reputation in respect of such work. It would be helpful for the partners to be allowed time to design a proper public health Education Outcomes Framework that would have wide application.

This work should certainly link to the perceived skills gaps that are being identified through this consultation and other skills audit processes that ought to take place as part of the process of establishing Public Health England.

In order to be effective, the eventual framework must map the outcomes against the competences for public health practice that are identified as essential.

Question 13 (Para 5.31):
How can flexible careers for public health specialists best be achieved?

If the only specialists to be recognised are to be those on an existing medical register or (currently) the UK Public Health Register then this does not really meet the meaning of "flexible". The CIEH regards many EHPs as specialists in public health and there are others in local authorities as well, such as planners and transport professionals, capable of becoming future leaders of the public health workforce.

EHPs are flexible in their learning and practice and the CIEH is flexible in meeting their education and training needs. We regard the environmental health profession as capable of good and effective practice. Flexible careers for specialists can be achieved through providing appropriate information, marketing, support and infrastructure. The public health training pathways need to be suitably flexible also, as is the case currently for EHPs wishing to pursue a career as a specialist in public health.

It would also be helpful going forward for there to be clearer understanding of the use of the description "specialist" and where the "professional" fits in with this definition. In addition, the interaction between specialists and the wider workforce, for example the ability of specialists to delegate tasks to others, will assist. So too will greater appreciation of the benefits of partnership working.

Career development is important for existing specialists and for those who will aspire to be specialists in the future. In order to ensure the success of the new public health system there ought to be no limit on ambition and ability to convert desire and talent into prominent roles and careers in public health across this multi-disciplinary workforce.

Question 14 (Para 5.38):
What actions would support the development of strong leadership for public health?

Leadership in public health involves many qualities. Local authorities supporting Directors of Public Health and their public health staff is a form of leadership, as is the role of the Directors of Public Health and their staff supporting communities.

A number of actions are needed to support strong leadership in public health. These range from direct support for leaders and would-be leaders – for example, a leadership programme – to a culture within the public health workforce of encouraging and supporting the emergence of leadership from all levels within the workforce.

An element of good leadership is the ability to promote partnership working, across an organisation and between organisations and this will be essential in bringing the two different organisations of local government and the NHS closer together.

There is a clear role for professional bodies in contributing to the design and delivery of programmes of education, training and support for leaders. The CIEH has been fully engaged with all of the various initiatives to develop leadership programmes in public health and other aspects of local authority services.

Within local authorities, EHPs are capable of demonstrating effective leadership, both in their partnership working with other professionals and their engagement with communities.

There is a risk of the strategy defaulting into a mode where only those with medical qualifications are regarded as the leaders, or indeed of professionals in other disciplines deferring to those with medical qualifications as though they are necessarily to be seen as leaders. What is important is to point up the progressive and innovative practice of all professionals and to assess who can best help in taking the whole public health workforce where it needs to be.

Question 15 (Para 5.43):
What actions can be taken, and by whom, to attract high-quality graduates into academic public health?

The question speaks of attracting high flier graduates into academic public health but of course high performing individuals would be welcome in all parts of the public health workforce.

Arguably, the top priority is to attract high flier graduates into frontline public health work. To pick out academia in this way demonstrates a lack of appreciation of public health as practice-led.

It will be helpful at all levels of the new workforce to support the building up of relevant evidence bases and promoting relevant research. For EHPs more encouragement and enabling of publication of papers would be welcome.

Question 16 (Para 5.50):
Are these the right actions to develop and strengthen the public health information and intelligence function? Who should be responsible for delivering these actions?

The health information and intelligence function received thorough and welcome attention in the Government's White Paper *Healthy Lives, Healthy People*. It is to be hoped that this consultation is not an indication that the Government's ambition in this regard is waning. The consultation document sets out too narrow a view of the wealth of evidence that exists and needs to be captured, collated, analysed and the lessons from it disseminated widely.

Question 17 (Para 6.3):
Do you have any evidence or information that would help analyse the impact of these proposals?

EHPs and others have evidence of good practice relevant to the delivery of England's new public health service. It is important to appreciate the wide range of public health activities carried out by EHPs and others. An example would be the contribution to good public health of food hygiene inspections and greater empowerment of the public through the growing Food Hygiene Rating Scheme.

The CIEH's publication Our health, our wellbeing contains a number of relevant case studies and a copy accompanies this response.

No doubt other professionals, for example, planners, can demonstrate the contributions that their work makes to good public health outcomes.

Chapter 5

About the Chartered Institute of Environmental Health

As a **Chartered professional body**, we set standards and accredit courses and qualifications for the education of our professional members and other environmental health practitioners.

As a **knowledge centre**, we provide information, evidence and policy advice to local and national government, environmental and public health practitioners, industry and other stakeholders. We publish books and magazines, run educational events and commission research.

As an **awarding body**, we provide qualifications, events, and trainer and candidate support materials on topics relevant to health, wellbeing and safety to develop workplace skills and best practice in volunteers, employees, business managers and business owners.

As a **campaigning organisation**, we work to push environmental health further up the public agenda and to promote improvements in environmental and public health policy.

We are a **registered charity** with over 10,500 members across England, Wales and Northern Ireland.

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Appendix 1

Examples of public health impacts and innovative practice in environmental health

Improving housing conditions in the private rented sector

Private rented homes are the worst maintained part of the housing stock and contain large numbers of vulnerable households and those living in fuel poverty:

- People living in private rented homes are over four times more likely to be living in a cold home than people living in social rented homes
- The private rented sector has a greater proportion of the most energy inefficient homes - those in Energy Performance Certificate Band G. They are twice as common in the private rented sector as in other sectors
- Half the properties in the private rented sector are not considered to be of a 'decent' standard by the Government

Excess cold - the Cost Calculator

CIEH commissioned research into the costs to the NHS of cold dwellings across England and in particular to private rented dwellings. The methodology used two different techniques for measuring and explained the relationship between Category 1 Excess cold (under the Housing Health and Safety Rating System) and Energy Efficiency Rating (EER) bands. This additional report more clearly defines the estimated costs to the NHS of Excess cold hazards and states these costs by Region.

The research estimates the likely costs to the NHS of private rented dwellings with F and G EER bands. This is associated, as far as possible, with dwellings with Category 1 Excess cold hazards. The cost to the NHS of Excess cold in the private rented sector puts this figure as somewhere between £50 million and £270 million dependent on the combination of risk likelihoods used. It is reasonable to assume that the cost to the NHS for not improving these dwellings will be at least £**145 million** per annum. The table below illustrates the potential regional and national impact:

Region	Number of Dwellings estimates to be Associated with Excess cold	Cost to the NHS of **NOT** improving these dwellings
North East	17,000	£5,497,000
Yorkshire and Humber	66,000	£13,968,000
North West	66,000	£10,493,000
East Midlands	67,000	£12,073,000
West Midlands	65,000	£12,823,000
South West	97,000	£24,717,000
East of England	68,000	£14,690,000
South East	128,000	£32,197,000
London	82,000	£18,878,000
All privately rented dwellings	656,000	£145,335,000

Excess seasonal deaths

Environmental health practitioners (EHPs) are at the forefront of efforts to combat excess cold and damp in the owner occupier and private rented sector and are important in addressing the wider impacts of climate change on health. In the UK, deaths are likely to fall because of milder winters, although in the last five years, more than 130,000 people over 65 have died from cold related illnesses during the winter months in Britain[1]. For EHPs who work in housing there are clear opportunities for input. EHPs can provide advice and assistance for occupants on issues such as improved insulation. They can also engage specific proactive interventions designed to identify and assist particular individuals or types of property. Improving our housing stock is a key component of reducing carbon emissions and has clear health benefits.

Healthier Menu Choices for Children when Eating Out

A public health nutrition project in Somerset funded by the Food Standards Agency and NHS Somerset

A public health nutrition project was undertaken in Somerset in 2009-2010 with the aim of improving the nutritional quality of children's menus when eating out. The project was funded by the Food Standards Agency and NHS Somerset to further their strategic goals of reducing child obesity and other diet-related health problems in the population. Environmental Health Officers from all five local councils in Somerset worked together to engage small independent catering businesses, primarily in the leisure and tourism sectors, in training on nutrition and healthier catering. The aim of the training was to improve proprietors' understanding of the business benefits of healthier catering and the effect of diet on health, as well as to offer practical suggestions on simple changes that can be made to catering practices to reduce saturated fat, salt and sugar in the food provided, whilst maintaining or improving financial margins.

Training was delivered by a nutrition consultant and involved a combination of educational seminars and one-to-one advisory visits to premises. Fifty caterers from 39 diverse businesses across Somerset participated in the training, including children's nurseries, cafés, pubs and restaurants. Visits were made to 22 of these businesses and four of them also received detailed nutritional analysis of their menus. Feedback on the training was 94% positive. Some businesses responded by changing their entire menus; some removed their special children's menus – chicken nuggets and chips, sausage and chips, pizza and chips – and instead offered smaller portions of the healthier adult menu items; and others made simple adjustments to recipes across the whole menu to reduce saturated fat, salt and sugar, and increase content of vegetables, fruit and whole grains. Evidence suggests that approximately 80% of the businesses made beneficial changes to their menus, whilst 20% made no changes at all. The work in children's nurseries was particularly encouraging because, in some cases, substantial changes to menus were made almost overnight, such as switching from white to whole grain varieties of bread, rice and pasta, increasing the use of plant source proteins and oily fish, and replacing sugary desserts with fruit-based dishes, without affecting demand and even increasing take-up of meals.

A comprehensive set of training materials was produced for this project which can now be used to train other businesses.

Bristol's home action zone

The Home Action Zone (HAZ) team at Bristol City Council targets areas of the city based on various local statistics including the house condition survey, and falls admissions to hospitals. The areas consist of between 800-1300 privately owned properties and the HAZ has evolved into a scheme which takes a holistic approach to health and housing rather than just looking at the structure of the property.

The team engages with the identified community through mailshots and door knocking every property in the area, talking as a result to approximately 40-50% of people. The team inspects around 20% of the houses in the area. Environmental Health Officers carry out standard house inspections in addition to making referrals to various other agencies and departments for the following free services:

- Handrails, grab rails and disabled equipment for people with disabilities or mobility problems (the Environmental Health Officers are trained "Trusted Assessors" which means that they can make direct referrals to the technicians to install handrails and grab rails without the need for an occupational therapist to visit, and with only a 4 week wait. This not only relieves the strain on the OT's but also potentially prevents falls and accidents in the home)
- Smoke detectors
- Security checks with extra window and door locks fitted
- Cavity wall insulation and loft insulation
- Carbon monoxide detectors
- Help to get people claiming the benefits they are entitled to
- Subsidised loans for works to remedy Decent Homes Standard failures
- Home safety grants (whilst we have funding) for works under £1000 to reduce category 1 hazards, including window restrictors, balustrades and levelling paths
- Referrals to GPs for people who are identified as being at a high risk of falling
- Referrals to the housing complaints team for category 1 hazards in private rented properties

For example in the most recent home action zone, as a result of finding them and making referrals, an elderly couple both went from claiming no financial help to both receiving higher rate attendance allowance at a total of £154.90 per week, £60 pension credit per week and council tax benefit. They also had levers fitted to their taps so that they are able to grip them, and a grab rail in the bathroom. A quote from their letter: " I can assure you that this will make a huge difference to our lives. One being we can stay warm without worrying about the bills".

Funding for the scheme has decreased drastically and the team is having to be ever smarter with the way it uses limited resources. Success in tackling health inequalities will depend on maximising available resources and using them in a targeted way in order to get value for money and help those most in need. Partnership working reduces duplication of tasks and services and draws on a larger resource and knowledge base.