Joint Strategic Needs Assessments and Joint Health and Wellbeing Strategies – draft guidance

Department of Health Consultation

Submission from the Chartered Institute of Environmental Health (CIEH)

Prepared by Ian Gray, Principal Policy Officer
21 September 2012

Contents:

Section 1 – Responses to the proposals for consultation

1. Purpose

We note the intention to provide 'further materials, including advice on good practice', to support health and wellbeing boards in implementing the final statutory guidance. The CIEH, as the professional body representing a key element of the public health workforce with more than a century of history in working in local government, wishes to participate in the production of such further materials and is able to contribute examples of good practice.

2. Context

The context is a powerful statement of the challenges to be faced through the 'continuous process of strategic assessment and planning'. It is essential that consideration is given at all stages to the unique contributions which environmental health practitioners can make as well as the ways in which their holistic approach can be incorporated into partnership approaches to 'address the wider determinants that impact on health and wellbeing'.

The CIEH is surprised and concerned that the role of Public Health England (PHE) is not identified and described. We are aware from other published documents and public presentations that PHE's support to the local public health delivery system will include

- Supporting the development of evidence based improvement initiatives through:
    - Provision of data, analysis, intelligence, evidence and expertise
    - Identification, cataloguing and coordination of best practice
- Professional support for the public health workforce (including appointments and professional accountability)
- Nationwide public health improvement campaigns including behavioural science and insight
- National delivery of health protection including expertise and co-ordination for incidents
- Publication of local PH outcomes
-

It is important that there is clarity about what is to be made available locally in carrying out the JSNA processes and in determining the JHWS, and this support can be accessed.

3. Duties and powers under the 2007 Act (as amended by the Act)

3.1 **Who is responsible for JSNAs and JHWSs?**

We note the statement that local authorities and clinical commissioning groups have an equal and joint duty and that the responsibility 'falls on the health and wellbeing board as a whole'. If there is not to be an executive power or authority vested in any particular agency or individual, then there will need to be a process for decisions, including the failure to provide agreement, to be challenged.

The list of additional members of health and wellbeing boards that can be included beyond the core members needs to include the district and borough councils within the area administered by the health and wellbeing boards or, as a minimum, representatives of the district and borough councils.

3.2 **What are Joint Strategic Needs Assessments (JSNAs)?**

We believe that it is a fundamental mistake to place almost all of the emphasis on the role being to carry out a local assessment of current and future health and social care needs. We believe that, important as it is, equal weight should be given to the 'asset-based approach' identified at point 13 in the reference material.

It will be clear from the outset that health and wellbeing boards will be unable to make the desired responses to all identified needs and it will be all too easy to fall back on the traditional and pragmatic approaches at the expense of innovation. It was a sobering lesson for many local authorities in carrying out community audits in preparing for the planning of their local responses to Local Agenda 21 (planning for sustainable communities) that very considerable amounts of activity were taking place in their communities - often previously unknown, unreported and unsupported. We believe that a key area of activity for every health and wellbeing board should similarly be to assess the range of assets within their communities that can help to meet identified needs and impact on the wider determinants of health as well as maintaining key aspects of the environment which support the maintenance of and improvements in health.

We welcome the intention that a range of both qualitative and quantitative evidence will be used and that JSNAs should also be informed by more detailed local needs assessments such as at a district or ward level, looking at specific groups (such as those likely to have poor health outcomes). It is this approach that lies at the heart of providing for local authorities to lead the development and delivery of public health and that priorities should be locally determined wherever possible.

However, there is a lack of conventional evidence in some areas and if required then evaluation and assessment of future impact would take time to create. Indeed, in some areas it can be argued that the need for action is obvious and popular and that further justification is not required. To be dogmatic about evidence, where it is patchy or non-existent, may serve to stifle innovation and the development of good practice. In the worst case scenario, it could conceivably lead to the loss of key areas of traditional and valued activity, including those traditionally associated with environmental health practice and other basic health protection and environmental management services.

To some extent this is addressed in the reference in the model shown as *Figure 1 – How JSNAs, JHWS and commissioning plans fit together,* which refers to 'evidence and collective insight' in answering the rhetorical question – 'What does our population and place look like?' However, there is nothing in the narrative text to describe what this can consist of and how it might be assembled and made available. This point should be addressed in subsequent guidance.

3.3 **What are Joint Health and Wellbeing Strategies (JHWSs)?**

We understand the intention that 'This is not about taking action on everything at once, but about setting priorities for joint action . . . ' but for the reasons stated earlier we believe that the JHWS could include actions which the health and wellbeing board has or would wish to identify as constituting assets within their communities that can help to meet identified needs and impact on the wider determinants of health as well as maintaining key aspects of the environment which support the maintenance of and improvements in health.

We welcome the statement that local evidence 'should not be overshadowed' by outcome measures from the NHS, Adult Social Care and Public Health Outcomes Frameworks and the Commissioning Outcomes Framework.

3.4 **Using JSNAs and JHWSs**

There is the requirement for upper-tier local authorities to work to improve the health of their populations and this is seen as an opportunity for local authorities to embed health improvement in all policy-making and decision-making. This is the 'Healthy Public Policy Approach' which the CIEH has always been an advocate for and sees Environmental Health Practitioners (and especially those working in local authorities as Environmental Health Officers) as important contributors.

However, this approach can only be effective if it takes full account of the responsibilities and services provided by district and borough councils which need to be properly recognised and valued. This is not reflected in the model shown as *Figure 1 – How JSNAs, JHWS and commissioning plans fit together.* In this model there is the intention for 'Involvement of partners and the community' but we have seen nothing in this consultation that will assure district and borough councils that their partner role will be recognised and that their concerns and contributions on a council by council basis will be sought and valued.

This is a key concern for the CIEH and its members because the EHO workforce is largely based within the district and borough councils. Failing properly to identify the need to engage with and marshal the contributions of the district and borough councils and the contributions of their workforce will be a severely limiting factor in achieving the Government's stated aims. The wording of any subsequent guidance must deal specifically with this point.

3.5 **Timing**

We do not believe that it is simply a matter of updating and refreshing JSNAs and JHWSs but also a rigorous process of assessing their validity and effectiveness at identifying and addressing the correct priorities. It is accepted that the Government will not wish to be directive about this, but the subsequent guidance can set out expected approaches that are most likely to be effective in the long term. In our view this will include engagement in a continual process of appraisal and reflection accompanied by hard measures to determine progress on 'measurable' improvements and ways for determining 'whether we are on the right road and are using the right milestones' (in the words of the Secretary of State for Health).

4. Promoting integration between services

The health improvement duty is an opportunity for local authorities to embed health improvement in all policy- making and decision-making. For this to be effectively implemented within their organisations greater integration of existing council services will need to be achieved.

However, this greater integration has to go much wider than merely within local authorities' services, both directly provided and commissioned. It has to extend, as the consultation

document says, to their work with their partner organisations. For upper-tier local authorities these partner organisations clearly include the district and borough councils.

Integrating local authorities' and NHS services has been a policy objective for some years. There are some fine examples of successful collaborative working. However, the success of the new arrangements for public health will in part be measured by how effectively such collaborative working will now becomes mainstream.

The needs identified in JSNAs and the priorities agreed in JHWSs represent a huge opportunity for the JHWS to assemble and deploy all of the efforts of the full range of council and partner activities to generate improving and high levels of health and wellbeing.

Whilst the CIEH is a strong advocate for the inclusion in the JSNA of housing need and housing conditions, the possibility of a local authority delegating responsibility for preparing its housing strategy is another matter. Local housing strategies are as much to do with understanding and influencing market forces and meeting public expectations across the variety of tenures as about meeting health needs.

5. Working in partnership to carry out JSNAs and develop JHWSs

The CIEH welcomes the requirement that health and wellbeing boards for county councils must involve the relevant district councils in developing JSNAs and that they should seek to work with district councils when preparing JHWSs and to agree with district councils how they will do this. However, we do not understand the reference to 'relevant' district councils and there will be the potential for serious misunderstanding if the basis is unclear for identifying which councils are and are not involved and if there are different and misunderstood levels of involvement. An inconsistent and unfair approach could seriously weaken arrangements and damage working relationships.

It is our view that all district and borough councils should be involved it ways that they consider to be appropriate for them, whether through individual membership, briefing groups or collective representation.

This point is also relevant to the 'general duties and powers' document.

6. Transparency and accountability

We support the expectations stated here for publication and promotion of JSNAs and JHWSs and for making data available.

7. Other duties

No comments to make.

8. Conclusion

No comments to make.

Section 2 – Responses to the consultation questions

Q1 Does the guidance translate the legal duties in a way which is clear in terms of enabling an understanding of what health and wellbeing boards, local authorities and CCGs *must* do in relation to JSNAs and JHWSs?

The guidance is clear in most respects, but it fails to identify the key roles and functions of the district and borough councils and to ensure that there will be arrangements to ensure that they are properly engaged with and represented at the health and wellbeing boards. We deal with this concern in detail elsewhere in our response to this consultation.

Of greatest concern to the CIEH and its members, and we hope the wider public health community, is that environmental health functions are entirely omitted from the functions of district and borough councils. We also deal with this concern in detail elsewhere in our response to this consultation.

We believe that there is an over-reliance on the use of the existing evidence base, and there needs to be greater emphasis on innovation and arrangements for encouraging improvements and additions to the evidence bases, including local interventions. Again, we deal with this concern in detail elsewhere in our response to this consultation.

Q2 It is the Department of Health's (DH's) view that health and wellbeing boards should be able to decide their own timing cycles for JSNAs and JHWSs in line with their local circumstances rather than guidance being given on this; and this view was supported during the structured engagement process. Does the guidance support this?

We have no comment to make on this.

Q3 Is the guidance likely to support health and wellbeing boards in relation to the content of their JSNAs and JHWSs?

The guidance makes some helpful suggestions on the required documents, but there are many omissions of services which could make a significant contribution to addressing the social determinants of health for example environmental health and occupational health and safety are not mentioned, despite all of the evidence of the relationships between work and health and unemployment and ill-health.

Q4 Does the guidance support the principle of joined-up working, between health and wellbeing board members and also between health and wellbeing boards and wider local partners in a way that is flexible and suits local circumstances?

The statements in the consultation documents do appear to support joined-up working. However, it should be recognised that this needs to happen within organisations, as well as between organisations and that much of the published material on partnership working demonstrates that true collaboration continues to present a challenge to both local authority and health organisations. Proposals should be developed in the subsequent guidance.

Q5 The DH is working with partners to develop wider resources to support health and wellbeing boards on specific issues in JSNAs and JHWSs, and equality is one theme being explored.

(a) In your view, have past JSNAs demonstrated that equality duties have been met?

The term equality can have different meanings and application: for some people it means equality of opportunity; for others equality of access to services; for others equality of outcomes; and for others it is linked to the elimination or avoidance of discrimination. We are not in a position to offer any assessment of the extent to which previous JSNAs have addressed equality issues. Future JSNA documents should be required to state specifically how equalities issues are being identified and addressed.

(b) How do you think the new duties and powers, and this guidance will support health and wellbeing board members and commissioners to prevent the disadvantage of groups with protected characteristics, and perhaps other groups identified as in vulnerable circumstances in your area?

The guidance is clear on groups with protected characteristics and other relevant groups.

Q6(a) In your view, have JSNAs in the past contributed to developing an understanding of health inequalities across the local area and in particular the needs of people in vulnerable circumstances and excluded groups?

We are not in a position to offer any assessment of the extent to which previous JSNAs have addressed health inequalities. Future JSNA documents should be required to state specifically how equalities issues are being identified and addressed.

Q6(b) What supportive materials would help health and wellbeing boards to identify and understand health inequalities?

We believe that there is a useful role here for professional bodies like the CIEH, Association of Directors of Public Health, Royal Society for Public Health and other representative organisations such as the Local Government Association, Royal Colleges and trade unions.

The CIEH for example offers accredited training and qualifications, provides training and continuing professional development programmes and publishes evidence, reference materials, guidance and toolkits.

Q7 It is the DH's view that health and wellbeing boards should make use of a wide range of sources and types of evidence for JSNAs and they should be able to determine the best sources to use according to local circumstances. This view was supported during the structured engagement process. What supportive materials would help health and wellbeing boards to make the best use of a wide range of information and evidence to reach a view on local needs and assets, and to formulate strategies to address those needs?

Sources of information need to be clear and simple to use, especially so that lay members of the boards can take a full and active role in debate and decision making. This does not mean 'dumbing down', but it does mean that specialists need to communicate well in an appropriate way for their audience. Some training for board members on the selection and

evaluation of evidence and also on its limitations would be useful. Access to published papers is an issue for local authority officers and members.

Q8 What do you think NHS and social care commissioners are going to do differently in light of the new duties and powers, and as a result of this guidance? – what do you think the impact of this guidance will be on the behaviour of local partners?

We would expect that the effects could be substantial if ambitious goals of integration of services are achieved. However, this will dependent largely on the commitment of, and relationships between, organisations and individuals at a local level. For those who are committed to working in partnership, the new duties and powers will be enabling, for others, changes might be more limited. Commitments made at a strategic level do not necessarily mean that changes will happen on the ground. There are a number of potential barriers including differences in organisational cultures. Early evaluation of the new system will be important.

Q9 How do you think your local community will benefit from the work of health and wellbeing boards in undertaking JSNAs and JHWSs? – What do you think the impact of this guidance will be on the outcomes for local communities?

It is vital that local authorities, clinical commissioning groups and their partners discharge effectively and meaningfully the new duty to involve the public. This must go much further than consultation "exercises".

Frontline public health practitioners, including environmental health practitioners, are skilled in their engagement with local communities and with appropriate leadership and support they can help to make public involvement arrangements successful.

Of course members of the public will be most impressed with services that are seen to be effective. This is why initiatives like "Make Every Contact Count" are so important. Referrals made as a result of one contact must be carried through by the appropriate partner organisation.

An immediate measure of success will be if local media feature the work of the health and wellbeing board and the public health workforce as headline news. This in turn brings us to an important potential partner and power for good in these reforms, namely local media organisations. In addition, the health and wellbeing boards and the public health workforce will need to be strong and effective in their communication of public health messages to local communities, using all appropriate channels including social media.

Section 3 – Comments on the general duties and powers relating to health and wellbeing boards

Establishment and membership of health and wellbeing boards

The CIEH believes that too little consideration is being paid to the key contributions that will need to be made by the district and borough councils in two-tier local authority areas.

This inattention is all too apparent in this document concerned with the establishment and membership of health and wellbeing boards where there is no mention of the inclusion of representation by district and borough councils in the section 'Core statutory membership'. The only mention is in the section 'Beyond the statutory core' where it is stated that:

Local authorities or health and wellbeing boards can add members to the board beyond that set out in the legislation. This could include representatives from other groups or stakeholders who can bring in particular skills or perspectives, or have key statutory responsibilities which can support the work of boards, such as those from the criminal justice agencies or relevant District Councils, or local representatives of the voluntary sector, clinicians or providers (whilst seeking to avoid potential conflicts of interest in relation to providers).

The phrase 'could include representatives from . . . . . relevant District Councils . . . ' is insufficient in that not only is it not set out as a requirement but it is not even expressed as an expectation.

The Government says that "localism" means that county and district councils will work together to make appropriate arrangements for the delivery of public health services in their areas and the Secretary of State has said that the challenge of co-ordinating public health services in two-tier local government areas will be addressed through the health and wellbeing boards. Co-operation between county and district councils in this respect is an expectation of the Government. The Department of Health says *"We expect upper-tier authorities with new public health duties to work with relevant district councils. We believe that health and wellbeing boards will need to involve district councils."*

The Public Health Minister told the Health Select Committee that she foresaw "some devolution of the public health budget down to the second tier, without a doubt." Other evidence to the Health Select Committee gave support for the involvement of district councils, as well as parish and town councils, in the public health service.

The CIEH believes that it essential for there to be positive arrangements and we have been commending all counties and district councils to ensure that they have good working arrangements in their localities. In particular, in two-tier local government areas of England, the CIEH believes that district councils should have representation on the county's health and wellbeing board, or some equally effective means of influencing its work. It is also open to county and district councils to agree for there to be a number of subsidiary health and wellbeing boards in the area of the county. However, whatever the arrangements, the CIEH believes that there would have to be very good reasons for excluding the district councils from the county health and wellbeing board.

To that end we have published a leaflet which sets out how the environmental health workforce of district councils, in areas of England with two-tier local government, can contribute to delivering public health services and improving health outcomes. *Public health services in two-tier local government in England,* CIEH, Public Health Series Number 3, June 2012
http://www.cieh.org/WorkArea/showcontent.aspx?id=42488

The CIEH produced this pamphlet because the information we were receiving was that the practical experience of co-operation at this local level is mixed. Some district councils have excellent joint working arrangements with their county council for public health strategic planning and service delivery, including representation on the health and wellbeing board and coordinated channels of communication. Others have no direct involvement yet in their county councils' shadow health and wellbeing boards and, as a result, some elected members and officers in district councils express frustration that they do not know enough about the public health plans of their county councils.

The CIEH is also concerned that in all of the various consultation and guidance documents to date there has been no reference to the specific public health functions of the port health authorities. These functions may be incorporated within the responsibilities of a local authority or delivered by a separately constituted port health authority. We believe that it is important for the Department of Health to demonstrate its understanding of the importance and uniqueness of these port health functions and their key roles in the front line of our national and international arrangements for public health and health protection.

Section 4 – Comments on the table of duties and powers

General concern about collective responsibility

The terms and vocabulary contained in this table appear to indicate that disagreements between the key parties, particularly the local authorities and clinical commissioning groups within the health and wellbeing boards, are anticipated. As a consequence, the duties and powers include provision for what is effectively the registering of objections. In the case of the NHS Commissioning Board there is provision, in the conducting of performance assessments, to include an examination of the working relationship and consultation arrangements between agencies. All of this may be considered to be necessary precautions against potential failures to develop effective working relationships.

However, the Government ought to follow through on its own rationale for returning the public health lead to local authorities. As the democratically accountable community leaders, local authorities and especially their elected members, are well used to a process of collective decision-making and ultimate accountability to their communities. Health and wellbeing boards are being established as committees of local authorities and there should be greater reliance on resolving issues through the democratic processes that have long been established in local government.

Publication of the JSNA and JHWS

There is similar ambivalence shown in relation to the publication of the JSNA and the JHWS. The table shows that both the local authority and the care commissioning group have a duty to publish the JSNA and the JHWS, however the duty is to be discharged via the health and wellbeing board. It is not explained why there is not a straightforward requirement for the local authority and the care commissioning group to jointly agree upon and publish (via the health and wellbeing board) the JSNA and the JHWS.

The power to delegate any local authority function (except scrutiny) to the health and wellbeing board.

The CIEH would wish to have clarification from the Government on why such a power is considered necessary and in what circumstances it would be appropriate for it to be exercised.

Section 5 – Comments on the framework of statutory duties

Meaning of requirement of 'duty to involve'

In paragraph 1.3 it is stated: *Section 116 also imposes a duty to involve the Local Healthwatch organisation for the area, the people who live or work in the area, and in the case of county councils, relevant district councils. In preparing JSNAs, it is crucial that the voice of local communities is heard and that the health and wellbeing board involves its local population. This duty does not distinguish between adults and children, and is expressed in the legislation as a requirement to involve people who live or work in the area. This involvement must be in addition to that of the Local Healthwatch organisation, and any relevant district councils. Others, such as professionals from outside the area, wider public sector partners, voluntary and community organisations and providers of services may also be involved in, or be requested to contribute to its development as is appropriate in order to develop the fullest possible*

The inclusion of this wording as part of a 'technical appendix which sets out the statutory framework' is considered to be to too imprecise in such a key area. Detailed advice on how the requirement of the 'duty to involve' should be met should be included in subsequent guidance.

Inclusion of 'the environment' as a 'health-related service'.

In paragraph 1.6 it is stated: *Health-related services are those that are not health or social care services, but may nonetheless have an impact on the health of individuals. It could also involve looking at how the health gains from factors such as transport, planning or the environment can be maximised. This may therefore involve considering the commissioning of health-related services by a broad range of local partners, such as for example, district councils, local authority housing services and strategies, local community safety partnerships, police and crime commissioners, local probation trusts, prisons, children's secure estate and all schools, including academies and free schools.*

The CIEH is pleased to see 'the environment' included as a 'health related service' and we fully support the statement which follows: *This ability to look beyond health and social care will be critical to the success of health and wellbeing boards.*

However, we are concerned that there is a need to develop a far better understanding of the variety of ways in which environment issues impact on health and to encourage the use of and development of the evidence base for effective interventions.

There is, in fact, a wealth of material published in so-called grey literature which demonstrates the imaginative ways in which public health practitioners seek to influence environmental factors that can help to determine health at both an individual and population level. There needs to be a greater focus on developing, reporting and promoting evidence-based practice in such areas. There are important roles for the DH and other Government departments in encouraging and supporting such research. As an example, the CIEH welcomes the recent announcement by the Secretary of State for Health that he has made a referral to NICE to develop guidance to support the prevention of excess winter deaths and

morbidity, and the health risks associated with cold homes. This is exactly the approach that the CIEH has been supporting and it needs to be taken in a range of areas in order that health and wellbeing boards can have the confidence to direct and commission work 'upstream' in preventing ill health and improving the quality of people's lives.

Delegation of local authority functions to health and wellbeing boards

In paragraph 2.11 it is stated: *The 2012 Act gives local authorities the power to delegate local authority functions to the health and wellbeing board. This creates potential opportunities for health and wellbeing board's* (sic) *to address factors that influence health and wellbeing – as long as the relevant services are within the local authority's functions and the local authority has delegated them to the board. For example, housing and leisure, substance misuse treatment; or other determinants of health could be considered by the health and wellbeing board, where delegated.*

The CIEH believes that this statement is confused in that it suggests that there could be delegation of functions such as housing and leisure, which are delivered by district and borough councils where there are 2-tier systems of local government in place, to the health and wellbeing board which will be operating at, or relating most closely to, the upper-tier level.

It is difficult to identify what benefits would be derived from such arrangements. In particular, they could undermine the local accountability which is a key ingredient in the 'localism' approach that is so strongly supported in other aspects of the new public health arrangements.

Section 6 – Comments on the summary of terms

County Councils

These are responsible for services across the whole of a county or city, like education, transport, planning, fire and public safety, social care, libraries, waste management and trading standards.

A much better explanation can be provided and should include a description of what is meant by 'upper-tier authorities' as the term is used without explanation elsewhere in the consultation documents.

District Councils

District councils cover a smaller area than county or city councils. They are usually responsible for services like rubbish collection and recycling, council tax collection and housing.

The assertion that district councils cover smaller areas than other arrangements of local government administration is inaccurate in any geographical context and also minimises the role and function of district and borough councils.

Environmental health services

Of greatest concern to the CIEH and its members is the omission of environmental health activities, which can perhaps be excused as a simple error, but which nevertheless will create the impression for some that these key and longstanding public health functions, which have become over time some of the most significant defining features of public administration in local government, are still not understood and appreciated.

Throughout the entire process of the development of the Government's proposals, the CIEH has been fully supportive by both engaging its members and also promoting the contributions which environmental health practitioners can make to improving health and reducing inequalities and maintaining the health protection measures which are so important, especially during the transition to the new organisational arrangements. In particular, we have ensured that both the Secretary of State and the Minister for Public Health are informed of our role and influence. The Public Health Minister has referred to environmental health practitioners as 'Guardians of Public Health'. We have also been actively involved in all relevant consultations and working groups and produced a variety of literature to ensure that environmental health is seen as a key element of the wider public health workforce, already in place and ready and able to engage with the health and wellbeing boards as they are forming.

To this end we have published a leaflet which states that environmental health practitioners are already performing key public health services through their duties in relation to the air we breathe, the food and water we consume, the condition of the housing we occupy, the protection of the land that we build, walk and play on from contamination, the places where we work and our protection from diseases. *What every health and wellbeing board needs to know about environmental health services,* CIEH, Public Health Series Number 1, October 2011
http://www.cieh.org/WorkArea/showcontent.aspx?id=39288

It will therefore be vital that health and wellbeing boards lock in the benefits of this work and integrate these activities with other public heath programmes for which they will be responsible.

In the circumstances it is difficult for us to understand why this key function of district and borough councils does not feature prominently in these consultation documents.

Government Open Data Policy

The government is opening up public data from the National Health Service, schools, criminal courts and transport as part of its transparency drive. The government aims to provide the public with more information about the performance of services.

Our CIEH members and others working in local government will be concerned to know how issues concerned with commercial confidentiality will be dealt with.

Local Asset

An asset could be formal or informal resources, including capacity within other organisations or the community that can be used to improve health and wellbeing outcomes and impact on the wider determinants of health, such as the ability of population groups to take greater control of their own health and manage their long-term conditions.

Public health is everyone's responsibility and frontline public health practitioners will be skilled at engaging individuals and communities in the work they do. There is however a balance to be struck between empowering and enabling individuals and communities to take more control over their lives (a significant feature in the Marmot report) and an abdication of leadership and governmental responsibility. Health and wellbeing boards need to be alert to ensuring that the right balance is achieved and be strong advocates for their communities if they identify weaknesses in leadership and support nationally.

About the CIEH

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.

For correspondence relating to this consultation response and for any further information

Contact:

David Kidney, Head of Policy
Chartered Institute of Environmental Health
Chadwick Court
15 Hatfields
London SE1 8DJ

www.cieh.org

The CIEH wishes to acknowledge the assistance received in the preparation of this draft document from Surindar Dhesi, PhD Student, Health Policy Politics and Organisation Group (HiPPO), School of Community Based Medicine, Manchester University