Purpose
The purpose of this paper is to inform BACCH members about the content of the Public Health (PH) White Paper, to examine the practical implications for child health practitioners and to document the BACCH response to consultation questions.

Précis with a focus on children in young people
The foreword rightly starts by acknowledging that the health inequalities between rich and poor have been getting progressively worse year on year, that Britain is now the most obese nation in Europe, with the worst rates of sexually transmitted infections, a relatively large population of problem drug users, and rising levels of harm from alcohol. Effectively tackling poor mental health alone could reduce overall disease burden by nearly 25% with considerable NHS savings.

The PH White Paper considers this as one of the greatest challenges of our generation; how can we create health through a vibrant and effective public health service, not just continue with a national sickness service?

*Healthy Lives, Healthy People* proposes "a radical new approach" (their words) and suggests that this approach will "reach across and reach out - addressing the root causes of poor health" in order to integrate mental and physical health strategies. Responsibility for this has to be shared between individuals, local government, the NHS, charities, local business and central government.

The approach will be:

*Responsive* - owned and shaped by local communities without undue interference from central government. This will be supported by a public health outcomes framework that complements and integrates the NHS and social care outcome frameworks.

*Resourced* - supported by a ring fenced public health budget which will not be immune to the cost reductions and efficiency gains. The total budget for Public Health England is estimated at £4 million.

March 2011
**Rigorous** - professionally led, based on evidence and delivered in an efficient and effective manner. New approaches will be rigorously evaluated and learning applied in practice.

**Resilient** - the creation of an integrated public health structure will make public health more responsive and resilient to future health challenges.

All public health functions will be within one organisation called Public Health England, which will be commissioned by the NHS Commissioning Board. This high-profile approach will be complemented by a Cabinet Subcommittee on Public Health. However, it is not clear how Public Health England will interface with public health in the local authorities.

This new approach will take a life course approach and focus attention on health and well-being in five key areas described as:

- **Starting well** - focusing on women before, during, and after pregnancy and the early years;
- **Developing well** - focusing on children and young people;
- **Living well** - focusing on conditions causing premature mortality;
- **Working well** - focusing on the health of people at work; and
- **Ageing well** - focusing on the health of the over 65s.

The public health strategy is in line with coalition policy intentions with localism at the heart of the system, with devolved responsibilities from central government supported by new freedoms and funding for directors of public health and local authorities. Therefore one of the key challenges will be to join up services both within areas, and with colleagues in neighbouring areas to minimise boundary differences and resulting ‘postcode lottery’. Organisationally, the Health and Well-Being Board is the structure to create focus and collaboration between the various Commissioners involved, the local providers, whether public, private or the community and voluntary sectors, to create action on the locally agreed public health outcomes to be achieved. There will be a ring fenced public health budget, with a new health premium to reward progress against the new outcomes, particularly inequalities. At the moment it remains unclear how the health premium will be calculated and what it will mean in real terms.

March 2011
Three new national organisations to support this new approach are proposed: a new National Institute for Health Research (NIHR), a School for Public Health Research, and a Policy Research Unit on Behaviour and Health.

The following critique from BACCH, while recognising the importance of the health of adults, especially parents to young people, will concentrate on the key elements reflecting the health of children and young people, ‘Starting well’ and ‘Developing well’.

Starting well

Early intervention and prevention is the key priority and an approach of "proportionate universalism" is favoured with an increased focus on disadvantaged families who will have increased access to:

- The Healthy Child Programme [3.6]
- Increased numbers of health visitors [3.8]
- Family Nurse Partnership Programmes [3.9]
- 15 hours of high-quality free nursery care [3.7]
- Services within Sure Start Children’s Centres
- Community budgets for families with complex needs [3.9]
- New intensive intervention models [3.11]

Developing well

- Excellent health and pastoral support - a hallmark of good schools [3.13]
- Healthy schools, healthy further education and healthy universities programmes in partnership with business and voluntary bodies [3.15]
- Strengthened PHSE programmes [3.16]
- Non-legislative solutions to tackle low levels of body confidence [3.16]
- "You're Welcome" young people friendly services to continue [3.17]
- New approaches for mental health promotion [3.18]
- Broadening the Change4Life programme [3.19]
- Greater access to high-quality physical education, including walking and cycling to school and a Paralympics style sports competition [3.20]
- Expansion of the Healthy Child Programme, including expanded talking therapies service. [3.21]
- School nurse health reviews and school entry and key transitions [3.22]
Healthy lives, healthy people: our strategy for public health in England

BACCH critique and consultation response

- A new vision to school nurses reflecting the public health roles [3.22]
- A new mental health strategy for teenagers-in development [3.23]
- Greater tobacco control [3.24-26]
- Raising participation in education to 18 by 2015 [3.28]
- Additional apprenticeship places and access to independent careers advice [3.28]
- Piloting a national Citizens Service [3.28]

Living well

Children in young people will also indirectly benefit from:

- Public Health Responsibility Deal which tackles food, alcohol, physical activity, health at work and behaviour change.
- Local sustainable transport and active travel
- Tackling inequalities, sustainability and climate change
- Mass Participation and Community Sport legacy programme
- Promoting access to green, yellow and blue spaces [3.36-37]
- Changes in licensing laws [3.38]
- Reducing smoking [3.39]
- Improvements in drug and alcohol treatment services [3.41]
- Improved sexual health services [3.43]
- Approaches to tackle violence and abuse (especially women and children) including the further development of sexual assault referral centres.

Further relevant papers on the following topics are due in the near future including:

- Health Visiting
- Mental Health
- Tobacco Control
- The Public Health Responsibility Deal
- Health Protection, Emergency Preparedness and Response
- Child Poverty Strategy
- Drugs
- Crime Strategy
- Social Mobility White Paper

March 2011
Healthy lives, healthy people: our strategy for public health in England  
BACCH critique and consultation response

- Welfare White Paper
- Special Educational Needs and Disability Green Paper
- Munro Review of Child Protection
- Graham Allen Early Intervention Review

Critique
This PH White Paper has been published at a time when the central importance of child health and inequality as a determinant of health and well being throughout the life course has been highlighted. There is renewed determination to reduce inequalities (Marmot report) and to tackle the determinants of health early (Frank Field and Graham Allen reports). It is essential for the NHS to be central to these ends (Wanless reports). BACCH strongly supports the full implementation of both Field and Allen reports as the backbone of the Public Health interventions in the UK, as the majority of subsequent health problems in adult life are generally established in the first five-years of life and supports the use of the Marmot report to embed tackling health inequalities within the White Paper. While the White Paper recognises this, there is relatively little explicitly about early interventions in the Foundation Years, and it raises the question about whether these are considered public health interventions and if they will be funded.

BACCH believes that the life course approach of the White Paper should be strengthened so that more emphasis is given to ensuring delivery and appropriate accountability systems to ensure positive public health outcomes relevant for pregnancy and early years.

The focus on vulnerability at key periods of transition is also welcome as there is a risk that in periods of financial constraint school age children and adolescents could be neglected. Four transition periods that are relevant to children and young people are emphasised (starting a family, starting school, changing from primary to secondary school and finishing school) [2.3].

Another welcomed emphasis is that on building resilience from early childhood, recognising that the relationship with carers in the first two years of life lay the foundation for mental health, which in turn builds the foundation for a healthy adult lifestyle. The phrases ‘emotional health’ and ‘wellbeing’ are used repeatedly throughout the White Paper. This is an important recognition of the impact mental ill-health and mental illnesses have on quality of life and use of health services.

March 2011
Public health capacity

While generally being supportive of a move to more local public health service, we have real concerns about public health capacity locally to deliver this challenging agenda. Public health has been considerably eroded over the last two decades and even investment in injury prevention programmes (a major cause of mortality, morbidity and hospital use) has been reduced to an absolute minimum. Though there are local exceptions, in general, public health capacity with a particular expertise/competence relating to children, young people is also lacking.

There should be greater capacity for clear leadership for children’s public health. Many departments of public health will have someone who leads on public health for children and young people, but very often this is just one of many areas that they are expected to lead on, resulting in limited time to address the issues and prioritise this work over competing priorities. It is important to acknowledge and welcome the transformational programme in Health Visiting (HV), a professional group that has been undervalued and poorly supported over the recent past. A criticism would be that school nurses (SN) have not had the same attention applied to them. The White Paper mentions their roles will be reviewed but lacks any detail or commitment to developing them as a professional group. HVs and SNs should be acknowledged as key public health practitioners.

Public health support for GP Commissioning Consortia

Public health support for GP commissioning will be provided by the NHS Commissioning Board. However we believe that public health skills are essential to the commissioning process and the new GP Commissioning Consortia will require access to local skills and knowledge. ‘Achieving equity and excellence for children’ has highlighted the potential gaps in expertise, especially with regards to safeguarding and children with complex health needs. Along with public health support for Commissioning consortia, we agree that there is a need for specific child health expertise within the consortia.

The important concern here is that there will be no requirement that GP Consortia will need to work with local public health teams, or with local child health experts, to commission childrens services. If they wish to work with private companies they are free to do so. The potential lack of engagement with those who have local knowledge could lead to poor commissioning decisions.
Developing the evidence base
A great deal of child public health practice does not have a sound evidence base. Concerns regarding research involving pregnant women, children and young people means that it often isn’t done and therefore decisions need to be made on lower quality evidence or on ‘best practice’. One of the risks of localism is that across the country there will be groups of people trying to tackle the same problems but working in isolation. There ideally needs to be a mechanism for disseminating good practice to avoid wasted time and money being spent reinventing the wheel.

BACCH would therefore fully support the development of evidence based public health, perhaps through the National Institute for Health & Clinical Excellence (NICE) and complemented by the creation of a National Institute for Health Research (NIHR), a School for Public Health Research, and a Policy Research Unit on Behaviour and Health. We see this as an essential investment to the public health infrastructure, but the development of these units must not delay the implementation of the cost-effective programmes suggested by Marmot, Field and Allen.

Resourcing the public health agenda
We would not want this to undermine the implementation of early interventions to support parents and children. There is extremely good evidence on the cost effectiveness of these interventions which would pay dividends in the future. The challenge is to find sufficient resources to implement them fully at a time in the child’s life when they are most effective. We would propose that priority within this public health agenda should be to support families, this being particularly important at the time of economic downturn. The focus should rightly be on developing high-quality preventative services rather than merely redistribution of income. Following initial pump priming, resources should be reinvested from the agencies which are likely to be beneficiaries of early interventions (see below).

Impact on other services
Social Care. If vulnerable families could be supported in the early years it is likely this would have a substantial impact on child protection/safeguarding systems. Evidence from the Family Nurse Partnerships pilots support this belief. Currently children’s social care assess and support families where there are concerns, but if these concerns could be managed with community-based
intervention programs, the residual number of children where parents were unable to use the support available should be small, and children’s social care resources could be focused on complex families with multiple simultaneous needs, for example, learning difficulties, substance misuse, mental health problems and domestic violence.

Advancing technology and health care mean that children with increasingly complex health needs are surviving where previously they would not. This will place an increasing burden on children’s social care services and will necessitate significant improvements in the transition arrangements for those moving from child to adult care.

_Education_. Poor "school readiness" often accompanied by disorganised behaviour is a real issue in primary schools. The focus on early intervention should considerably improve behaviour and concentration at school and reduce the need for 1:1 support.

The White Paper highlights partnership working with schools to improve child health and wellbeing, but the emphasis has shifted towards health for academic achievement rather than achieving health and wellbeing for its own sake, e.g. "good schools will be active promoters of health in childhood and adolescence because healthy children with high self esteem learn and behave better at school" [3.16]. There is no statutory duty to provide PHSE which is highly disappointing.

There is a disconnect between the ethos of the PH White Paper, which emphasises the role for health to work with schools, and the Education White Paper, which does not give any emphasis on working together with health services or in health promotion, and has an unrealistic view of school’s expertise in, e.g. promoting emotional health. There is concern that the excellent work started on improving multiagency working and communication between health and education will be eroded by the Education White Paper.

_Criminal justice system_. The majority of young people in the criminal justice system grow up in families who have had contact with the criminal justice system. These cycles of disadvantage can be broken through education and the building of resilient individuals with good self esteem and aspiration. One of the most important roles for paediatricians and those working in child health is to help keep a child in school and to help that child achieve. This is a clear example of the need for March 2011
closer working between health and education, and this is not emphasised adequately in the PH White Paper (and certainly not in the Education White paper).

In the long-term, if we can produce a new generation of children with empathy, social skills and behaviour that keeps them out of the criminal justice system, then one of the greatest beneficiaries will be the criminal justice system. (Almost 50% of all crime relates to the under 25-year-olds.) The cost to society is vast; if all the on-costs of crime are included there needs to be a creative discussion on how these systems can "pump prime" the necessary investment.

Commissioning of public health
Many of the interventions recommended by the Field and Allen reports might be considered outside the arena of public health, and yet these are very real public health interventions which would impact on the health and well-being of children and families for generations to come. Most of these interventions would be commissioned locally, and the interface with the National NHS Commissioning Board at a local level requires more thought. Given the emphasis of coalition policy to devolve decision-making and responsibility it is surprising that public health commissioning is retained at a national level.

Screening programmes require all the parts to be in place and working well together - should public health commissioning include cochlear implants programmes, if newborn hearing screening is a public health responsibility?

With increasing independence of schools, particularly the autonomy of Academies, how can the public health aspects delivered in education settings be guaranteed when there are no clear lines of accountability? All schools will have greater control of their own budgets and will be able to choose who they wish to work with (just like GP Commissioning Consortia). They will have no requirement to work with local public health, nor with the Healthy Schools Teams.

Commissioning of health visiting services [3.8] discusses linking with early years, maternity services and primary care, but does not discuss linking with education, or school nursing at the time of transition to school. This is an important omission.
Provision of public health

The future envisioned for the NHS is one of multiple social enterprise organisations competing with one another to drive quality based on patient choice. The provision of public health often runs counter to this model, requiring cooperation and collaboration between various providers to create effective public health programmes. This will require real local knowledge and at times direction, to ensure all the parts fit together. It is difficult to see how this will be achieved when the various parts may be commissioned by different organisations. This could be overcome with a strengthened Child Health and Well-being Board, or devolving commissioning responsibility for children’s services to a Children’s Trust. Whichever system is favoured there will need to exist strong leadership, governance and accountability structures and processes. The transition from PCT to Local Authority Public Health provision will be a test of this strength.

Regulation and oversight of public health programs

The role of the Care Quality Commission, Ofsted, Monitor, and other national regulatory agencies are not mentioned in relationship to public health. Logically they should regulate the whole public health programmes and where this applies to screening programmes all the elements, with the active support for innovation and improvement. This is particularly important for public health programmes where improvement will generally not be driven by choice and competition.

Incentives for reduction in inequalities

The new health premium is intended to reward local authorities who make the greatest inroads into reducing inequalities. However, the authorities with the most resistant health inequalities will find reduction most difficult to achieve, and there is a risk of reinvestment in areas with least inequalities which will create further inequalities between different geographical areas. Careful consideration will need to be given to resource investment to reduce inequalities. Investment needs to acknowledge the baseline from which inequalities are being measured and to recognise good practice to be when the health of the most disadvantaged is shown to improve.

Investment and disinvestment decisions

There is good evidence to suggest that investment in early interventions produces real returns in the longer term. The challenge is how to create short-term investment in order to release resources in the longer term. The other challenge is that resources should be released from special educational

March 2011
Healthy lives, healthy people: our strategy for public health in England

BACCH critique and consultation response

needs, child and family therapy services, substance misuse services and the criminal justice system and there should be a clear mechanism to enable disinvestment from these services and reinvestment in early interventions during a Foundation Year’s in years to come.

Consultation questions and BACCH response

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

Primary care staff work at the front door of the "national sickness service" and have huge opportunities to identify individuals who are "at risk" of developing future problems. They need to be supported by evidence based services that can help individuals and families make better life choices in relationship to their health. To do this effectively they will need new competencies around the assessment of risk/harm in identifying those individuals who will most benefit from the new public health services, and cogniscent of the reality of limited resources and capacity to take on referrals, e.g. obesity services in the community. GPs are quite capable of identifying families with behaviours that increase the risk of poor health; their real challenge will be to enable individuals and families to make better life choices. This is largely outside of the capacity of primary care. If the healthier choice is the easier choice then it will be adopted. To be the easier choice there needs to be political willingness to take on industry (e.g. the food industry, the alcohol lobby, the tobacco industry, car manufacturers) and to legislate for change that promotes health.

Individuals in primary care can contribute to the public health agenda by ensuring the best management of established conditions and taking an active, proactive approach to the prevention of secondary complications/impacts of the primary condition, for example, diabetes, coronary heart disease and their impact on everyday living. The greatest contribution that individuals in primary care can therefore make is to help individuals prevent the onset of disease in the first place.

March 2011
GP Commissioning Consortia will need to fully understand public health, the development of public health strategies and evaluation of public health programmes because they are substantially different from clinical interventions. More often they are about reducing hazards (health protection) or promoting resilience (health promotion) and neither can be monitored by health outcome measures in the short-term. This will be particularly challenging for Consortia when their primary focus will be the commissioning of acute and community services. There is a real risk that public health will be sidelined. By specifying that GP Consortia are required to work with local public health experts will enable the opportunity to ensure that the preventative component is not forgotten.

It will be difficult to ensure that this is seen as core business by many GPs whose day to day business will NOT bring them in contact with well clients on their list who may be at particular risk. We recognise that a presence of commissioning GPs alongside those with child public health expertise sitting together on Child Health and Wellbeing Boards will be essential to ensuring appropriate health promotion prioritisation.

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

NICE has been developing a programme of public health activity and guidance, some of which has recently been forced to close prematurely (e.g. some of the programmes around prevention of injuries in the road environment, or the evidence supporting spatial planning and health). The Government should reinstate such programmes and enable NICE to continue to review the evidence of public health interventions, recognising that other agencies such as planning, housing, leisure, child care providers, etc. all contribute to the delivery of improved health for children and young people. Many of the public health interventions relating to children will revolve around better parenting, emotional resilience, promotion of mental health and protection from injury/substance misuse. This agenda is wider than the health service as many of these interventions will be delivered by 'early intervention services' that should be considered under the public health umbrella. Expert health led support for universal services gives the opportunity for improved engagement of local key child public health issues, e.g. vitamin D deficiency, parenting and mental health issues, or school food policies, and requires both raising awareness and developing local solutions.
c) Public health evidence: how can Public Health England address current gaps such as using the insights of behavioural science, tackling wider determinants of health, achieving cost effectiveness and tackling inequalities?

Progress to date has focused on evidence based clinical interventions and this should continue, but be complemented by evidence based social care and education programmes. NICE should be enabled to undertake collaborative or complementary reviews of the evidence with synthesis experts at the Institute of Education and SCIE. Throughout the health service there needs to be a greater focus on evidence policy and evidence based service delivery models are going to complement the clinical focus. Behavioural science knowledge should be used equally to address not only individual behavioural change but also institutional behavioural change, e.g. industry self regulation. The Government should demonstrate its commitment to improved health for children and young people by acknowledging that health outcomes need to be measured in the long term, and that success against problems that are dependent on individual or societal behaviour change cannot be measured in the short term.

d) Public health evidence: what can wider planners nationally and locally contribute to improving the use of evidence in public health?

Good evidence needs to be translated, not only for public service staff to implement, but also for patients/parents/children and young people. The population as a whole has low levels of health knowledge and generally lacks the ability to critically evaluate information available through the World Wide Web. Likewise, they have low levels of knowledge to judge the effectiveness or indeed equity of services. A strategy to improve the quality of services based on competition and consumer choice is unlikely to be effective with low levels of health literacy and health knowledge. Knowledge of health, health conditions and health services should be a statutory part of the national curriculum to ensure the entire population into adulthood with a basic knowledge to enable them to make healthy choices throughout their adult lives. BACCH recommends that PHSE should be a statutory requirement in schools where the best evidence in healthy behaviours can be disseminated to young people in meaningful ways. This should also include media literacy training to increase children and young people’s awareness of both positive and negative marketing strategies and to enable them to recognise poor health messages and be resilient to media and peer pressures to engage in poor health behaviours.
There is clear evidence of the need for increased levels of physical activity in the population. Schools should be required to facilitate the early adoption of healthy physical activity behaviours through the requirement to provide a minimum of physical activity per week as part of the curriculum.

e) **Regulation of public health professionals:** we would welcome views on Dr Gabriel’s Scally’s report.

If we were to pursue voluntary registration, which organisation would be best suited to provide a system of voluntary regulation of public health specialists?

Faculty of Public Health together with other organisations are advising on this question.

f) **Additional comments**

Paragraph 4.30 acknowledges the disruption caused by the transition to new NHS structures and this report predominantly focuses on primary prevention yet in the definition of public health the roles of public health service planning, improvement and service commissioning is barely acknowledged in this White Paper. In a period of transition it could be argued that public health skills within the NHS are vitally important to ensure the right balance of investment between the various competing priorities. Few clinicians have public health skills and therefore there are real risks caused by the transition to new NHS structures caused by the lack of clinical engagement of clinicians and public health practitioners, other than General Practitioners.