1. The Richmond Group (RG) is a coalition of ten of the leading health and social care organisations in the voluntary sector. We work together as a collective voice to better influence health and social care policy and practice, with the aim of improving the care and support for the 15 million people we represent, who are living with long term conditions in England.

2. Public health interventions and behaviour change policies are vital in order to prevent many long-term health conditions (LTHCs) from occurring in the first place and, for those who live with LTHCs, to increase their likelihood of avoiding any further health complications and to live as well as possible. Therefore, the RG has made prevention one of its key priorities and welcomes the Health Select Committee’s inquiry into public health post-2013.

Key role of prevention

3. NHS England’s Five Year Forward View recognised the increasing pressures facing the NHS and highlighted the important role that prevention needs to play in order to reduce the burden of avoidable disease, in terms of ensuring the long-term sustainability of the health service and the health of the population. “The first argument we make in this Forward View is that the future health of millions of children, the sustainability of the NHS, and the economic prosperity of Britain all now depend on a radical upgrade in prevention and public health” and in particular the document called for “hard-hitting national action on obesity, smoking, alcohol and other major risk factors”.

4. Around 15 million people in England live with a LTHC.1 Many of these conditions could have been prevented, yet long term conditions now account for up around 70% of the health service budget.2 The Office of National Statistics has estimated that nearly one in four deaths are potentially avoidable3 and are usually linked to the common behavioural risk factors: if every woman in the UK was regularly physically active, 9,000 fewer women would develop breast cancer each year;4 75% of cardiovascular disease is preventable;5 smoking is responsible for over 80%

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2 Five Year Forward View, NHS England, October 2014.
of all deaths from lung cancer and Chronic Obstructive Pulmonary Disorder (COPD).\textsuperscript{6}

5. In addition to the human costs, preventable ill health costs the NHS and it costs the economy. The rise in potentially preventable conditions is expected to increase NHS costs by £5 billion a year between 2011 and 2018.\textsuperscript{7} A recent analysis by the Nuffield Trust suggested that without action to reduce the need for hospital care, the equivalent of 22 extra hospitals will be required by 2022.\textsuperscript{8} Between 2011 and 2018,\textsuperscript{9} and sickness-absence related costs to employers and taxpayers (a large proportion of which could have been prevented) have been estimated at £22 billion a year.\textsuperscript{10}

6. Once people are diagnosed with a long term condition, secondary prevention is also important for those who could benefit from lifestyle and behaviour change interventions. This is the case for medial risk conditions, such as hypertension and hypercholesterolemia, which can lead to a range of other cardiovascular conditions. Investment in behaviour interventions for all those recently diagnosed with a long term condition can also prevent the rapid deterioration of health and the rise in multi-morbidity, which is very costly to the NHS.

7. For example, people with serious mental illness are at greater risk of developing other long term conditions and experience worse outcomes. Compared to the general population, people with mental illness are twice as likely to develop diabetes\textsuperscript{11} and three times more likely to die from heart disease.\textsuperscript{12} Compared with the general population, men with schizophrenia die, on average, 20.5 years earlier, and women with schizophrenia die 16.4 years earlier. One-third of these preventable deaths are attributed to suicide or injury but the rest are from physical causes, and particularly from heart conditions and stroke.\textsuperscript{13} Offering tailored public health interventions when people are first diagnosed with a mental health condition would therefore reduce both the shocking health inequalities faced by this group and the avoidable cost of preventable physical health conditions.

\begin{footnotes}
\footnote{6 The Health and Social Care Information Centre, Statistics on Smoking: England 2012}
\footnote{7 House of Commons Health Committee, Managing the care of people with long term conditions, Second Report of Session 2014-15, 3 July 2014}
\footnote{8 The Nuffield Trust, NHS hospitals under pressure: trends in acute activity up to 2022, 6 October 2014}
\footnote{9 House of Commons Health Committee, Managing the care of people with long term conditions, Second Report of Session 2014-15, 3 July 2014}
\footnote{10 NHS England, Five Year Forward View, October 2014.}
\footnote{11 Royal College of Psychiatrists, 2013 ‘Whole person care: from rhetoric to reality. Achieving parity between mental and physical health’, Occasional paper OP88}
\footnote{12 Osborn, DPJ., 2007 Physical activity, dietary habits and coronary heart disease risk factor knowledge amongst people with severe mental illness: a cross sectional comparative study in primary care. Social Psychiatry Psychiatric Epidemiology pp 787-93.}
\footnote{13 Diabetes UK, Fact File 13, Protecting the cardiometabolic health of people with severe mental illness}
\end{footnotes}
8. Much still remains to be done in order to maximise the potential of prevention. In 2011, the UK has signed up to deliver the World Health Organisation (WHO) objective to reduce the mortality from the four main non-communicable diseases – cardiovascular disease, cancer, chronic lung disease and diabetes – by 25% by the year 2025.\(^{14}\) This means that by 2025, there need to be 2.6m fewer adults smoking, 1.3m more adults being physically active, 9.9m people bringing their salt intake down to recommended maximum daily levels and 430,000 fewer adults drinking at harmful levels in the UK.\(^{15}\)

9. Furthermore, behavioural factors affecting health and well-being are disproportionately distributed amongst those from lower socio-economic households. More than half of the inequality in life expectancy between social classes is now linked to higher smoking rates amongst poorer people.\(^{16}\) Those most disadvantaged tend to do worst in terms of their health.\(^{17}\) There is a gap in overall life expectancy between the most and least deprived areas of England of 6.8 years for women, and 9.2 years for men.\(^{18}\) However there is an even bigger gap in healthy life expectancy between the most and least deprived areas, of 15.5 years for women and 17.5 years in men.\(^{19}\) Starting to close this gap would also make a substantial difference to meeting the challenges of an ageing society. Reductions in public health funding will not only reinforce, but exacerbate this health inequalities gap.

10. Whilst regulations, like standardised packaging for tobacco products, are due to be introduced shortly,\(^{20}\) the impact of these may be limited if there is inadequate funding for smoking cessation services, which directly support people to overcome this very addictive behaviour. The Department of Health should also provide strong tobacco control policy leadership when it updates its Tobacco Control Strategy in 2016. This is a good opportunity to continue the momentum on this important area of prevention.

11. Until now, not enough action has been taken to safeguard people’s health. In order to accelerate positive behavioural change towards prevention and self-care, a coordinated approach to prevention across all sectors and levels of government is required. The RG would like to see greater clarity and accountability on prevention. The Department of Health, NHS England and Public Health England (PHE) need to publically set out how they will better align their responsibilities for

\(^{14}\) World Health Organization, Draft comprehensive global monitoring framework and targets for the prevention and control of noncommunicable diseases, March 2013
\(^{15}\) What’s Preventing Progress? The Richmond Group of Charities, Oct 2014.
\(^{16}\) Five Year Forward View, NHS England, October 2014.
\(^{18}\) UCL Institute of Health Equity, Marmot inequality indicators overview presentation, September 2014
\(^{19}\) UCL Institute of Health Equity, Marmot inequality indicators overview presentation, September 2014
\(^{20}\) Regulations include the introduction of standardised packaging for tobacco products (due to be introduced in 2016), ban on smoking in cars carrying children and other measures to regulate the sale of electronic cigarettes to under-18s.
improving prevention efforts, and report on these, building on the ambitions set out in the NHS England’s *Five Year Forward View*.

**Local Authorities’ public health budgets**

12. In 2013, the NHS underwent a major re-organisation, as part of the legislation set out in the Health and Social Care Act 2012. Structures for public health services changed as a result: commissioning powers were transferred over from the NHS to Local Authorities (LAs). Some of these services are mandatory for LAs to commission, including sexual health services, NHS Health Checks and national child measurement programmes, whilst other services are commissioned according to local priorities. These include stop smoking services, harmful drinking services as well as weight management and physical activity interventions.21 These last four areas tackle the key behavioural factors contributing to the development of the majority of the LTHC that member charities of the RG represent.

13. In July 2015, the Department of Health announced cuts of £200m to LA public health budgets, reducing their in-year 2014/15 budget by a flat 6.2% cut to every Local Authority in England.22 The RG23 as well as many other key healthcare bodies - including the King’s Fund24 and the Faculty of Public Health25 - opposed these cuts in principle, believing these to be both short-sighted and a false economy for the health service as a whole.

14. These cuts have been announced less than two years after the Government’s *Living well for longer call to action* stated that LAs should “lead the charge” to reduce preventable early death, through their new health improvement responsibilities and ring-fenced budget.26

15. The recent Autumn Statement outlined the Government’s intention to move towards a model of local authorities funding their public health spending from retained business rates. The ring-fence on public health spending will therefore only be maintained until 2017-18. The RG is concerned that this will lead to reduced funding for public health and increased variation between local authority areas.27

16. The overwhelming evidence for the value for money and cost-effectiveness of public health is well established.28,29 We are concerned that at a time when LA

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22 Local authority public health grant allocations 2015/16: Government response to public consultation on in-year savings, Department of Health, November 2015.
23 Letter published in *The Times on behalf of Richmond Group CEOs*, 8 July 2015.
24 *Cuts to Public Health Spending: the falsest of false economies*, David Buck, King’s Fund blog, 6 August 2015.
25 UK Faculty of Public Health response to the Department of Health consultation on Local authority public health allocations 2015-2016, 28 August 2015.
finances are under increased pressure, there is a risk that these funds – as well as those made available to support social care – will be used to cover existing and urgent activity rather than invested in further upstream efforts to improve prevention. Cutting from an already small public health budget will also have negative consequences, both for long-term sustainability of the NHS and for the future health of the public. The Faculty of Public Health estimates that the reduction in public health expenditure will generate at least £1 billion additional extra costs to health and social care.\(^\text{30}\)

17. Whilst the move of public health commissioning to LAs has the potential to integrate public health considerations in all parts of the system and across wider determinants of health, the public health budget also needs to be adequate to deliver not only the baseline services, such as those listed in point 12, but also to introduce more innovative and joint up programmes. In its report *What’s Preventing Progress*, RG called for prevention to be a key consideration in all LA responsibilities, including across education, transport, housing, environment, planning and social care, where resources need to be harnessed for improving the health and wellbeing of citizens.

18. Whilst the RG does not represent the interests of public health professionals, it would be concerned that cuts to public health budgets may also impact on the public health capacity and expertise available to LAs in order to fulfil all of their public health functions.

**Impact on NHS services**

19. Local Authority budgets fund the posts of the Directors of Public Health who provide expert advice not only to LAs but also to Clinical Commissioning Groups (CCGs). Cuts to the public health budget could therefore have an impact on the expertise provided to healthcare services. Conversely, the Association of Directors of Public Health (ADPH) estimates that Councils commission between 40-80% of their public health work from NHS services.\(^\text{31}\) Smaller public health budgets will therefore have some direct impact on NHS services. A recent rapid survey by the Faculty of Public Health showed that of 259 specialist public health respondents, the majority thought that the following services would be adversely affected by the cuts: interventions to reduce obesity: 77%; smoking cessation: 63% and; child health: 63%.\(^\text{32}\)

20. Although commissioning arrangements vary across different areas, CCGs tend to commission some of the higher level public health interventions. An example of

\(^{29}\) Judging whether public health interventions offer value for money, NICE, Sept 2013

\(^{30}\) UK Faculty of Public Health response to the Department of Health consultation on local authority public health allocations 2015 – 2016.

\(^{31}\) Local Government Association (LGA) briefing: Public Health Funding, Wednesday 15 July 2015.

\(^{32}\) Children’s health could be affected by cuts, say public health experts, Faculty of Public Health, June 2015.
this is specialist support for weight management, with patient assessment from a Multi-Disciplinary Team, as well as access to bariatric surgery.\textsuperscript{33} These more intensive interventions are more costly than the brief interventions provided by LAs, so individuals only get referred to them once they have tried the simpler interventions and not been successful. Any cuts to public health budgets of LAs and the reduction of brief interventions is likely to impact on CCG expenditure, as the current arrangements rely on some people not needing to be progressed on to these more costly specialist services.

**Making every contact count**

21. Millions of people come into contact with NHS services every day. They do so at a time when they need help and when their health is on their mind. These contacts are prevention moments – opportunities to intervene, encourage and support people in making changes to their life when they are at their most receptive. This is particularly important in reducing health inequalities, since the most disadvantaged groups may also have the least contact with services before serious ill health is diagnosed.

22. The RG is calling for the NHS and public sector workforce to be required and enabled to make every contact count. The NHS needs to equip everyone who has contact with patients and service users with the skills to support them to live better, healthier lives. NHS England needs to produce a plan that shows how all NHS staff will be supported and required to develop these skills. Health Education England and the medical Royal Colleges need to ensure that supporting self-care and behaviour change and motivational interviewing are included in the training of all NHS staff.

**Public Health England**

23. The RG welcomes the regional and national awareness campaigns carried out by PHE since it was set up in 2013. Evaluations of the Be Clear on Cancer campaigns have shown improvements in earlier diagnoses of different cancers and increased awareness of symptoms.\textsuperscript{34} PHE should continue these public awareness programmes going forward. PHE has also run several behaviour change campaigns, such as Stoptober and Dry January, and is planning another campaign on Healthy Ageing. This is welcomed by the Richmond Group but these campaigns should be built upon and linked to other areas of public health and to behaviour change services for those who want to act on the messages, in order to maximise their effectiveness.

24. It is concerning that PHE’s 2015/16 budget is also £30m lower in real terms, compared to the previous financial year.\textsuperscript{35} These year-on-year reductions due to

\textsuperscript{33} Weight Management Services – what’s your view? Mid Essex CCG, Feb 2015.

\textsuperscript{34} \url{http://www.cancerresearchuk.org/health-professional/early-diagnosis-activities/be-clear-on-cancer/programme-evaluation}
inflation will reduce PHE’s ability to lead on prevention and may limit its spend on research, insight, and evidence based awareness campaigns in future, even if there are no actual cuts to its budget.

25. LAs also contribute resources to supporting national and regional awareness-raising campaigns launched by PHE, so the recent public health cuts may have an additional detrimental effect on the impact and success of PHE’s future campaigns, if fewer resources were available to provide this support locally.36

26. We would also like to see adequate resource allocated in order to achieve the ambition on prevention. We are concerned about the potential impact of the reduction in the public health budget to Local Authorities. Independent economic assessments have highlighted the adverse consequences of this for the health and wellbeing of the communities served, as well as the increasing future demands on the NHS. Many public health services are cost saving, meaning that this action is likely to cost the Treasury much more than £200 million in the long run.

27. Addressing the public health needs of the whole population necessitates joint working, shared commitments and longer term vision across all government departments if it is to be effective. The Department of Health, NHS England and PHE need to publically commit to, and provide the leadership and resources, to better align their responsibilities for improving prevention efforts, if we are to achieve the ‘radical upgrade in prevention and public health’ to deliver the ambitions set out NHS England’s Five Year Forward View.

14 December 2015