RSPH response to Prevention Green Paper consultation

(Department of Health and Social Care) October 2019

The Royal Society for Public Health (RSPH) is the world's oldest public health organisation and is dedicated to protecting and promoting the public's health and wellbeing. We have over 6,500 members across the health and public health workforce, including those working in the NHS, universities, charities, local authorities, and industry. The proposals put forward in this document have been informed by consultation with our membership.

1: From life span to health span

Which health and social care policies should be reviewed to improve the health of: people living in poorer communities, or excluded groups?

Given the deeply entrenched health inequalities in the UK, and the widening life expectancy gap,[1] RSPH welcomes the inclusion of health inequalities within the Green Paper and its vision for the prevention of ill health. There are three public health challenges in particular that are marked by a strong social gradient.

Tobacco continues to be one of the greatest factors in health inequalities in the UK, accounting for half the difference in life expectancy between the richest and poorest deciles.[2] Secondly, obesity rates at all ages are also strongly linked to social class. As explained further in sections 5 and 6, this can only be addressed by radically overhauling the obesogenic environment we live in, and which too often leaves individuals and households on lower incomes with only the cheap and unhealthy options available to them. Finally, alcohol policies such as minimum unit pricing and duty increases should be implemented, and would likely have a significant effect on health inequalities (as outlined in relevant sections below).

With regards to addressing health inequalities through the NHS, RSPH also supports plans laid out in the Long Term Plan for a change to NHS commissioning allocations for CCGs so that a higher share of funding is targeted at areas with high inequalities.[3]

RSPH endorses the principle that any adequate response to health inequalities in the UK must maintain a central focus on modifying the environment in which people make choices. For instance, obesity-

[1] A review of recent trends in mortality in England, 2018, PHE https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/827518/Recent_trends_in_mortality_in_England.pdf

[2] Marmot M. Fair Society, Healthy Lives: The Marmot Review: strategic review of health inequalities in England post-2010. 2010.

[3] https://www.kingsfund.org.uk/publications/nhs-long-term-plan-explained#prevention

related interventions which restrict or modify the choices available to individuals are most effective at changing behaviour.[4, 5] In contrast, interventions relying on voluntary behaviour for their success are typically both less effective and more likely to increase health inequalities.[6]

Therefore, any interventions relying on voluntary and individual behaviour change should be 'stress-tested' for any potential unintended consequences of this kind before implementation. This is especially important given the Government's laudable commitment to putting health inequalities at the heart of its prevention agenda.

2: Intelligent health checks

Do you have any ideas for how the NHS Health Checks programme could be improved?

RSPH welcomes the review of NHS Health Checks. There may be an opportunity to incorporate personalisation into the checks for enhanced individual support; however, we must be careful to avoid either a deterministic narrative or an 'individual responsibility' narrative. A more valuable aspect to review would be to the extent to which mental health is included in the Health Checks. The checks should take a holistic approach, assessing overall wellbeing by looking at physical and mental health at the same time.

RSPH would like to see the review look in detail at how the Health Checks may be impacting health inequalities, if there is variable uptake depending on socioeconomic group, gender, ethnicity, and other factors. The possibility of delivering Health Checks in non-traditional settings should also be explored, as a way of increasing uptake in potentially hard to reach groups.

Another potential area for improvement is with regards to alcohol consumption and harm. The NHS Health Check could play an important role in preventing and treating alcohol-related conditions but current effectiveness is patchy. Healthcare Professionals' training in asking questions about alcohol should be improved, and it should be mandatory to record patients' responses on alcohol, to ensure that appropriate support is provided.

[4] Hillier-Brown, F.C., et al. "The Impact of Interventions to Promote Healthier Ready-to-Eat meals (to eat in, take away or to be delivered) sold by specific food outlets open to the general public: a systematic review, *Obesity* Reviews, vol 18 no. 2, 2016, pp. 22-246.
[5] Mcgill, Rory, et al. "Are Interventions to Promote Healthy Eating Equally Effective for All? Systematic Review of Socioeconomic Inequalities in Impact." BMC Public Health, vol. 15, no. 1, 2015, doi:10.1186/s12889-015-1781-7.
[6] White, M., Adams, J., & Heywood, P.(2009-04-22). How and why do interventions that increase health overall widen inequalities within populations?. In Social inequality and public health. : Policy Press. Retrieved 4 Jun. 2018 (link)

3: Supporting smokers to quit

Smoking remains the leading cause of premature death in the UK, so RSPH is delighted to see the Government's commitment to a smoke-free England by 2030.[7] Similar commitments in Wales and Northern Ireland would be strongly encouraged. However, without a concerted approach to tackling the health inequalities reflected in smoking rates, those from poorer backgrounds may be left behind.

Principal in these efforts must be the raising and distribution of funds for effective and comprehensive tobacco control strategies through a 'polluter pays' levy on the tobacco industry. We endorse proposals set forth by Action on Smoking and Health (ASH) for the implementation of a Tobacco Control Fund, to be collected by DHSC and dedicated to public education campaigns, smoking cessation treatment (through e-cigarette friendly local stop smoking services), and enforcement activity.

Smoking during pregnancy is the leading modifiable risk factor for poor birth outcomes, including stillbirth, miscarriage and pre-term birth. As a member of the Smoking in Pregnancy Challenge Group, RSPH have welcomed the Government's ambition to reduce smoking at time of delivery (SATOD) to 6% or less by 2022.[8] However, SATOD rates have plateaued since 2015 hovering at slightly below 11%[9] and, as identified in the Green Paper, there is substantial geographic variation with local rates ranging from 1.6% to 25.7%.

The 6% ambition will not be met without targeted activity to support women facing most barriers to quitting. This should include a national incentive scheme targeting women in high prevalence communities. Financial incentives are an effective and cost effective way of supporting pregnant women to quit smoking during pregnancy and remain quit post-partum.[10] [11] This must be delivered alongside comprehensive implementation of NICE guidance[12,13] including support for women's households and families to quit.

Taxation increases have proved extremely effective at driving down smoking rates. RSPH endorses further increases on the tobacco tax escalator of 5%, with an additional increase of 10% for hand-rolled tobacco (HRT). The additional hike for HRT is to redress the current misbalance wherein HRT is significantly cheaper than factory-made cigarettes.

RSPH also supports e-cigarettes as an important harm reduction tool. The evidence to date shows they are substantially less harmful than smoked tobacco, and three randomised trials have indicated they are

---

7 https://publichealthmatters.blog.gov.uk/2018/09/25/health-matters-stopping-smoking-what-works/

8 Department of Health and Social Care. Towards a smokefree generation: a tobacco control plan for England. 2017.

9 NHS Digital. Statistics on Women's Smoking Status at Time of Delivery: England. 2019.

10 Notley C, Gentry S, Livingstone-Banks J, Bauld L, Perera R, Hartmann-Boyce J. Incentives for smoking cessation (Review). Cochrane Database of Systematic Reviews. 2019. Issue 7. Art. No.: CD004307.

11 Smoking in Pregnancy Challenge Group. Evidence into Practice: Supporting smokefree pregnancies through incentive schemes. 2019

12 NICE guidance. PH26. Smoking: stopping in pregnancy and after childbirth. 2010.

13 NICE guidance. PH48. Smoking: Acute, maternity and mental health services. 2013.

an effective quitting tool (as well as by far the most popular quitting aid).[14,15,16,17] If e-cigarette manufacturers were to be better supported in meeting the requirements of the Medicines and Healthcare products Regulatory Agency (MHRA) with their e-cigarette products, this could pave the way for e-cigarettes to be prescribed on the NHS. This would help reassure many smokers that they are comparatively safer than cigarettes, and reduce any financial barriers that low income smokers may face to switching to a lower risk-profile product.

4: Eating a healthy diet

How can we do more to support mothers to breastfeed?

Breastfeeding has health benefits for mother and baby, and should be encouraged to give all children a healthy start in life.[18]

We welcome the Government's commitment to reinstate the Infant Feeding Survey, to measure breastfeeding rates and infant feeding habits and assess the impact of the actions taken on infant feeding.[19] We recommend that this survey takes place at suitable intervals in line with the discontinued Infant Feeding Survey.

We recommend that the Government develops a national strategy to increase initiation and continuation of breastfeeding that sets and monitors breastfeeding targets and ensures local breastfeeding support is delivered to mothers. This should include adequate funding for Local Authorities, who commission the services to support breastfeeding. We welcome the increase to the Public Health budget in the September 2019 spending review, but the Government must ensure funding is sustainable so that authorities can continue to provide local children's services to protect breastfeeding.

How can we better support families with children aged 0-5 to eat well?

The Healthy Start scheme is an invaluable source of nutrition for children most in need. The vouchers have the potential to have a significant positive impact by providing low income families access to fruit, vegetables and cow's milk, all of which are necessary for healthy development.

Earlier this year it was revealed that because the vouchers are not being promoted, more than 130,000 eligible households have missed out.[20] It has been estimated that in 2018 this was equivalent to £26.8

14 E-cigarettes and heated tobacco products: evidence review. March 2018. PHE

15 Hajek, Peter, et al. "A randomized trial of e-cigarettes versus nicotine-replacement therapy." *New England Journal of Medicine* 380.7 (2019)

16 Walker, Natalie et al. "The effectiveness and safety of combining nicotine patches with e-cigarettes (with and without nicotine) and behavioral support, on smoking abstinence: findings from a large randomised trial" SRNT 2019

17 Jackson, Sarah, et al. "Moderators of real-world effectiveness of smoking cessation aids: a population study." Addiction (2019)

18 https://www.nhs.uk/conditions/pregnancy-and-baby/benefits-breastfeeding/

19 2019. Cabinet Office, Department of Health and Social Care. *Advancing our health: prevention in the 2020s – consultation document*.

20 https://www.huffingtonpost.co.uk/entry/exclusive-coalition-of-charities-warn-free-food-scheme-failing-low-income-families_uk_5cf1308be4b0e8085e38b490?utm_hp_ref=uk-homepage

million. Alongside a number of charities and health groups, we called for the Government to better promote the scheme to make full use of it.

If implemented properly, the scheme has great potential to help combat the rising rates of childhood obesity. We know that healthy food is three times more expensive than unhealthy food;[21] the scheme can help those at the greatest disadvantage in the most deprived areas, and therefore begin to address the gap in obesity between children from the most affluent and poorest backgrounds. It establishes eating patterns, forms healthy habits for life and shows children what food is good for them. It must be utilised to equip parents to safeguard the health of their children and the next generation. We recommend that the Government develops a strategy for promoting the scheme, including funding promotional materials for Health Visitors to distribute.

We also urge the Government to commit without delay to a comprehensive 9pm watershed on High in Fat, Salt and Sugar (HFSS) products, and restrictions on in-store price promotions for unhealthy foods. Both these approaches will make it easier for parents to protect children from the impact of unhealthy food promotion and advertising.

5: Support for individuals to achieve and maintain a healthier weight

How else can we help people reach, and stay at a healthier weight?

We support the policies that have been announced as part of the Childhood Obesity Plan, and want to see swift implementation of these.

- Soft Drinks Industry Levy (SDIL) – we want to see the revenue generated by the SDIL continue to be ring-fenced for healthy eating programmes in schools and equipment for physical activity. The SDIL should be extended to milky drinks, and there should be a consultation on whether it should also apply to food.
- Reformulation and reduction – we support product reformulation and the calorie, sugar and salt reduction programmes from Public Health England. The programmes should be regularly reviewed, with mandatory measures in place for manufacturers who fail to meet the targets.
- Advertising restrictions – there should be a comprehensive 9pm watershed on high in fat, salt and sugar (HFSS) adverts on TV and online. This should be extended to places with areas of high child exposure, such as sports venues. Cartoon characters on HFSS products intended for children should also be considered for restriction.
- Price and location based promotions – we have called for restrictions to promotions in the retail environment. Our report, Health on the Shelf,[22] demonstrated that supermarkets can encourage healthier choices by not having these types of promotions on HFSS products.
- Out of home calorie labelling – some companies have voluntarily done this already, and we recommend it becomes mandatory, based on a clear and consistent system.
- We are supportive of plans outlined in the Prevention Green Paper to hold a consultation on front of pack food labelling before the end of 2019. We look forward to responding to this consultation in due course, and will recommend clear and consistent nutritional information appears on all products.

[21] https://foodfoundation.org.uk/wp-content/uploads/2019/02/The-Broken-Plate.pdf
[22] https://www.rsph.org.uk/our-work/policy/obesity/health-on-the-shelf.html

RSPH also believes that Information about the calorific content of alcoholic drinks should be more widely available. Specifically, calorie and nutrition information should appear on the labels of alcohol products. Consumers should not have to seek out this information – for example, on other websites or apps – before purchase.

6: Staying active

Have you got examples or ideas that would help people to do more strength and balance exercises?

In order to encourage greater physical activity levels at a population level, and in a way that accrues to people across the socioeconomic spectrum, there is a need for wider environmental change. Funding is required to enhance the physical activity offer, such as active travel.

Our report, Routing Out Childhood Obesity,[23] made a series of recommendations to improve places to go for physical activity, and active travel, particularly with regards to young people:

- Youth-led improvements to green spaces.
- Physical signage outside school gates directing children to their nearest park or green space as they leave school.
- Open up school grounds during the school holidays.
- Councils to consider implementing and extending the 'School streets' scheme, transforming roads outside schools, so that only pedestrians and cyclists can use them at school start and finish times.
- The Department for Transport update traffic sign regulations to permit the building of zebra crossings without beacons or zig-zag lines.
- Cycle storage to be made available at all schools, enabling more children to cycle to school.
- Safe and segregated cycle lanes separated from traffic-heavy roads to be established, tracking popular routes to schools.
- The Department for Transport to propose a revised funding settlement for active travel. The Government must increase spending on active travel now, and provide future funding that is sustained, long-term, and increases as a proportion of overall transport spend over time.

Investment in active travel must also be seen as a key pillar of Government's strategy to address air pollution (see section 11).

We recommend the Government invests in opportunities for physical activity, including strength and balance exercises.

[23] https://www.rsph.org.uk/our-work/policy/obesity/routing-out-childhood-obesity.html

7: Taking care of our mental health

There are many factors affecting people's mental health. How can we support the things that are good for mental health and prevent the things that are bad for mental health, in addition to the mental health actions in the green paper?

Mental health discourse in the UK has in the past focused on expanding treatment access and capacity without the necessary parallel discussion of what can be done to improve prevention and thereby reduce demand on services. The prevention of mental ill health can be improved via the promotion of mental wellbeing.

In supporting the good mental health of the public, whilst preventing the things that are bad, we endorse a life course approach. Resilience can be built throughout childhood with early intervention, and support should be provided through school, college and university, in the workplace and at all stages in life.

It is a welcome step that Personal, Social and Health Education (PSHE) will be made mandatory in schools from September 2020 and we strongly recommend that a key component of PSHE focuses on mental health and wellbeing.

Mental health is another area where alcohol consumption – which we believe has been somewhat overlooked in the Green Paper – plays a significant role. Alcohol is a depressant and can lead to long-term mental health issues either directly or by causing ill-judged behaviour. The links between alcohol and mental health have repercussions outside treatment – for example for the police and justice system and in Accident and Emergency services. Tackling alcohol harms and mental health problems in a way that recognises their mutually reinforcing relationship can help address health inequalities.

Finally, RSPH is calling for greater acknowledgment of the harms to mental health from gambling and gaming platforms. We have recommended that a mandatory levy on the gambling industry be explored, with the intention of using the funds to shore up treatment services for gambling addiction and support prevention services for mental health.

Have you got examples or ideas about using technology to prevent mental ill-health, and promote good mental health and wellbeing?

There is a huge role for technology to play in supporting good mental health. In recent years, social media has played an increasingly prominent role in the lives of almost four billion users globally[24] and

[24] We Are Social (2019). World's Internet Users Pass the 4 Billion Mark. [online] Available at: https://wearesocial.com/blog/2018/01/global-digitalreport-2018 [Accessed 12 Mar. 2019]

for a generation of digital natives, having a social media account is fast becoming the norm: 1 in 5 children aged 8-11 have a social media account, rising to 7 in 10 children aged 11-15 years[25], and 91% of 16-24 year-olds use the internet for social media[26].

Our 2017 report #StatusofMind, as well as the subsequent 2019 report published following our inquiry with the APPG on Social Media (#NewFilters), considered the impact of social media platforms specifically on children and young people's mental health and wellbeing. It was revealed that social media can have a range of positive effects on mental health, including: providing a platform for self-expression, enhancing social connections, and supporting learning. Almost two-thirds (63%) of young people reported social media was a good source of health information. [27,28]

On the other hand, findings included that pressure to conform to beauty standards perpetuated and praised online can encourage harmful behaviours to achieve "results". These behaviours and outcomes included disordered eating and body shame, and that 46% of girls reported social media having a negative impact on their self-esteem. Further findings included that young people using social media to find support for mental health conditions are at high-risk of unintentional exposure to graphic content.

In light of these findings, we are calling for action to maximise the positives while mitigating the negatives of social media on young people's mental health and wellbeing. We are calling for the UK and Devolved Government's to:

- Establish a duty of care on all social media companies with registered UK users aged 24 and under in the form of a statutory code of conduct, with Ofcom to act as regulator.
- Create a Social Media Health Alliance, funded by a 0.5% levy on the profits of social companies, to review the growing evidence base on the impact of social media on health and wellbeing and establish clearer guidance for the public.
- Publish evidence based guidance for those aged 24 and younger to avoid excessive social media use.
- Urgently commission robust, longitudinal research, into understanding the extent to which the impact of social media on young people's mental health and wellbeing is one of cause or correlation and into whether the "addictive" nature of social media is sufficient for official disease classification.

As a broader message around the relation between digital innovation and public health, RSPH is clear that under no circumstances must technology be considered a panacea. Any benefits to public mental health through technological initiatives must be supported by a comprehensive strategy to address the

[25] Children and Parents: Media Use and Attitudes Report 2017, Ofcom (2017) https://www.ofcom.org.uk/__data/assets/pdf_file/0020/108182/children-parents-media-use-attitudes-2017.pdf p103

[26] Office for National Statistics (2016). Internet access – households and individuals, Great Britain: 2016. online] Available at: https://www.ons.gov.uk/peoplepopulationandcommunity/householdcharacteristics/homeinternetandsocialmediausage/bulletins/internetaccesshouseholdsandindividuals/2016 [Accessed 12 Mar. 2019].

[27] #StatusOfMind, 2017. RSPH https://www.rsph.org.uk/our-work/campaigns/status-of-mind.html

[28] New Filters, 2019. A report of the All Party Parliamentary Group on Social Media https://www.rsph.org.uk/our-work/policy/wellbeing/new-filters.html

social and economic factors in which the causes of mental ill health are so firmly rooted. Often, people living in the most deprived areas and most at risk of poor mental health are also less likely to use apps and other digital tools. There should therefore be, for any proposed technological solution to a public health problem, a presumptive action to test for a potential impact on health inequalities before implementation.

8: Sleep

We recognise that sleep deprivation (not getting enough sleep) is bad for your health in several ways. What would help people get 7 to 9 hours of sleep a night?

In our 2016 report, Waking up to the health benefits of sleep, RSPH revealed that over half (54%) of the public have felt stressed about poor sleep. Despite being a core pillar of our health and wellbeing, the importance of sleep is frequently underestimated.

This report revealed almost four in five long term poor sleepers suffer from low mood and are seven times more likely to feel helpless. This can be a vicious cycle with stress, anxiety, depression and poor mental health contributing to difficulties sleeping. In the context of interpersonal relations, sleep quality has been linked to greater marital conflict and poorer relationship satisfaction[29]. The repercussions for mental health are particularly severe.

Persistent insomnia increases the risk of developing severe depression and suicidal behaviour and world authorities who publish diagnostic classifications of mental disorders now recognise that sleep problems may be implicated in the causation and maintenance of psychiatric disorder rather than being a mere symptom[30]. Moreover, analysis suggests that sleep disturbance (such as insomnia and nightmares) is associated with an almost threefold increase in completed suicides[31].

Given the key role of sleep in so many aspects of health and wellbeing, and in underpinning a range of key health behaviours – alongside the need for effective treatment of disorders of sleep such as insomnia and sleep apnoea – we continue to urge the government to develop a national strategy for sleep. The cross-cutting nature of sleep underlines its primary importance, and sleep should be embedded as a priority area. A sleep strategy must target individuals across the life course, addressing the factors outside of individual control.

[29] Gordon, A., Chen, S. (2014). The role of sleep in interpersonal conflict: do sleepless nights mean worse fights? Social Psychological & Personality Science, 5, 168-175

[30] American Psychiatric Association. (2013). Diagnostic and statistical manual of mental disorders (5th ed.). Arlington, VA: American Psychiatric Publishing.

[31] Pigeon, W.R., Pinquart, M., Conner, K. (2012) Meta-analysis of sleep disturbance and suicidal thoughts and behaviors. Journal of Clinical Psychiatry, 73, e1160-1167

The multi-dimensional nature of sleep means that cross-departmental responsibility may be needed. Sleep has wide-reaching implications for disease, physical and mental health, healthy ageing, education, transport, employment, the NHS and business. Addressing all of these issues will need work across a number of departments under the direction of a minister of state

Drinking alcohol can also cause disruption to sleep. Evidence-based interventions that reduce alcohol consumption can improve sleep patterns and improve general health.

Social media can also have a negative impact on our sleep. As revealed in our 2017 #StatusofMind report, one in five young people waking up during the night to check messages on social media. However, while social media and technology are usually viewed as negative influences on sleep, there are many apps which have been shown to improve stress and anxiety levels, thus potentially improving sleep. In 2018, RSPH launched a free e-learning programme, "Understanding Sleep: don't hit snooze on your health", which adopts a preventative approach and will provide useful information, relevant to all members of the general public, around the link between sleep and health and wellbeing. Government investment into resources such as these could play a pivotal role in improving the public's understanding of the importance of and helping them achieve a good night's sleep.

Other wider factors also play a large role in determining that quality of sleep. Social and environmental determinants such as poor housing, environmental noise, and financial worries all shape an individual's wellbeing in many ways, with sleep quality and quantity being one of them. It should be emphasised that, while sleep hygiene and the other factors outlined in this section are significant considerations, the wider context of one's living conditions are the most important root causes.

9: Prevention in the NHS

Have you got examples or ideas for services or advice that could be delivered by community pharmacies to promote health?

We support the continuation of flu vaccine services from community pharmacies. We encourage the Department to review whether introducing other adult vaccinations to community pharmacy, such as shingles and pneumococcal, could also have benefits for uptake. It should also be reviewed whether NHS vaccine services could be delivered in settings additional to pharmacy and surgeries, such as hospitals, community centres, village halls and pop-up clinics.

The inclusion of new providers in the immunisation programme, however, must be supported by reliable data-sharing networks with primary care. This includes ensuring community pharmacies and other potential providers are integrated with the ImmForm system. Any new providers of vaccinations would need to be well integrated with primary care networks, with clear responsibilities and shared local leadership for winter season and immunisation planning.

Immunisation is a hugely important preventative service that the NHS provides. Other wider initiatives are required to reverse the decline in uptake seen across many vaccines in recent years. We need to ensure GPs have the technology and training to have automatic call/recall services in place, reminding their registered patients of upcoming required vaccines. We need innovative and far-reaching public campaigns to make the case for vaccinations, both in the physical and social media world, that engage parents and outshine anti-vaxxer messages. We also support the swift publication of the Government's vaccine strategy, and would refer to our submission to DHSC with regards to this strategy for a more detailed account of our recommendations.

RSPH also continues to support pharmacists in playing an important role in supporting the delivery of smoking cessation. This can involve initiating conversations about smoking at various key moments. These could be, for example, during purchase of stop smoking aids; if they identify recurring symptoms common among people who smoke like persistent coughing; or when dispensing medications for conditions that are related to smoking status. They can also support smokers to quit by always referring to local stop smoking services where they exist, offering advice on e-cigarettes as a quitting aid, and can aid in monitoring smoking status by delivering carbon monoxide tests.

However, the benefits that can be offered by community pharmacy must not be seen as a substitute for comprehensive smoking cessation services elsewhere. This includes within the NHS, where RSPH is pleased to see the Government's commitment to be treating all smokers admitted to hospital for tobacco addiction by 2023/24.[32] Building on the success of ongoing integration into secondary care trusts, RSPH would also like to see tobacco addiction treatment integrated into primary care. Finally, it is vital that local stop smoking services – which are now only commissioned by 56% of local authorities where they were once universal – are reinstated across the country, to ensure all smokers have access to the best evidence-based support.[33]

Overall, pharmacies are ideally placed to deliver local public health interventions, with 95% of the population within a 20 minute walk of their local pharmacy.[34] Pharmacies are already nationally commissioned to deliver the flu vaccine through the national flu vaccination service, and should be considered suitable candidates for further health and prevention services as well.

10: Children's oral health

What should the role of water companies be in water fluoridation schemes?

[32] NHS England. The NHS Long Term Plan. NHSE: 2019.
[33] Action on Smoking and Health and Cancer Research UK. A changing landscape: stop smoking services and tobacco control in England. 2019.
[34] Pharmacy: A way forward for public health. 2017, PHE. https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/643520/Pharmacy_a_way_forward_for_public_health.pdf

The evidence on the efficacy and safety of water fluoridation is unequivocal.[35,36] It is a cost effective intervention that would yield immediate cost savings, and RSPH regards it as the principal measure which can improve the oral health of children and the nation as a whole. [37] Water companies and local authorities should work together to ensure it is implemented without delay, with a focus on areas with high prevalence of tooth decay.[38]

The Government should also consider emulating the Scottish Childsmile project in the rest of the UK. This initiative, involving the delivery of supervised tooth brushing in schools, has been evaluated extensively, found to have a hugely reduced poor oral health in children, and awarded Best Practice status by the EU commission for doing so.[39] As a home-grown prevention initiative with a watertight evidence base and which pays for itself within the lifetime of a government, opportunities for roll-out of this programme to the rest of the UK should be explored.

11: Creating healthy spaces

Air Quality

Approximately 10% of UK lung cancer cases and 3,600 cancer cases annually are caused by outdoor air pollution (PM10 and PM2.5).[40] For those affected, air pollution reduces life expectancy by an estimated 11 years. [41] The Government's 2019 Clean Air Strategy was a welcome first step, but does not go far enough in its targets for air quality levels. For example, the current concentration limit for PM2.5 is 2.5 times the WHO guideline limit.

RSPH would like to see the Government introduce new limits for PM2.5 and PM10 concentration levels that are in line with the WHO guidelines, and make a legally binding commitment to meet these levels by 2030.

[35] https://www.cochrane.org/CD010856/ORAL_water-fluoridation-prevent-tooth-decay
[36] https://www.ada.org/en/public-programs/advocating-for-the-public/fluoride-and-fluoridation/fluoridation-facts
[37] https://www.bma.org.uk/-/media/files/pdfs/news%20views%20analysis/bma_fluoride.pdf
[38] For more information, see the Oral Health Foundation submission to the Health and Social Care Select Committee Inquiry into Dental Services, 2019.

[39] http://www.child-smile.org.uk/professionals/index.aspx
[40] Cancer Research UK (2018) How air pollution causes cancer (website)
[41] Further information: https://www.healthyair.org.uk/

Neighbourhoods and high streets

In our 2019 report, *Routing out childhood obesity,*[42] we looked at the small window of time during which young people travel to and from school every day, and identified this as a crucial context for influencing the diet and activity of young people. We set out a number of recommendations for enhancing the physical activity offer for young people (see section 6), and called for comprehensive planning and licensing measures to be taken forward with the aim of restricting and reducing the number of unhealthy fast food takeaways near schools. This is work that must be carried out at the local authority level, but for this to be successful councils will require backing from central government both in terms of adequate funding and facilitating knowledge-sharing between planning, licencing and public health departments across the UK.

In late 2018 we published *Health on the High Street: Running on empty*, looking more broadly at the high streets of the UK and how they can support health and wellbeing. We made a series of recommendations aiming to inject life into the nation's high streets, maintain their community spirit, and make retailers' offers more health promoting.[43] Key recommendations included HM Treasury to review how businesses are taxed to ensure that online businesses are not put at an unfair advantage compared to the high street, and MHCLG to provide local authorities with more powers and support to restrict the opening of new betting shops and other unhealthy outlets.

Alcohol

Alcohol harm is experienced not only by drinkers but by their families, friends, colleagues and others. Reducing the affordability and accessibility of alcohol can lead to lower levels of crimes, and support healthy living in the home.

Progress on road safety has ground to a halt, and England and Wales share one of the highest drink drive limits in the world. Lowering the drink drive limit to 50mg alcohol/100ml blood, and enforcing this limit would lead to a reduction in drink driving deaths by at least 10%.

There is no single solution to tackling alcohol-related harm, but international evidence suggests that tackling the affordability and availability of alcohol is most effective. At a population level, Minimum Unit Pricing can target the cheapest, strongest alcohol consumed by young people and those drinking at harmful levels. A review of the Licensing Act, with greater restrictions on the off-trade and perhaps measures such as the Early Morning Restriction Order as used in Australia, can provide results at community level.

[42] See *Routing out childhood obesity.* 2019, RSPH. https://www.rsph.org.uk/our-work/policy/obesity/routing-out-childhood-obesity.html
[43] See *Health on the High Street: running on empty.* 2018, RSPH. https://www.rsph.org.uk/our-work/campaigns/health-on-the-high-street/2018.html

12: Active ageing

What is your priority for making England the best country in the world to grow old in, alongside the work of Public Health England and national partner organisations?

RSPH believes work must be done across a range of areas if we are to meet the needs of an ageing population, and regards the mid-life MOT as an important part of the offer from the Government. Our 2018 report, *That Age Old Question*[44] looked at the impact of ageism in society, and made a series of recommendations.

Employers should support wellbeing and resilience, in preparation for later life. This includes support that prioritises psychological and emotional wellbeing in later life, as an addition to approaches that focus merely on the financial. Retaining older people within the workforce is also an important priority. Employers should also follower the spirit of "Retain, Retrain and Recruit", a framework pioneered by Business in the Community.[45] Specific policies would include statutory carers' leave for employees, and encouraging employers to commit to availability of flexible working patterns and a public commitment to tackling age bias and promoting age diversity within an organisation.

RSPH has also called for the bringing together of services such as nurseries, youth clubs, and care homes under the same roof. Such policies can offer great opportunities to improve integration within communities, combat loneliness among older residents, address the shortfall in nursery provision, and ultimately save costs through consolidating provision.

13: Prevention in wider policies

What government policies (outside of health and social care) do you think have the biggest impact on people's mental and physical health? Please describe a top 3

RSPH believes there should be more clarity and transparency on where responsibility for the prevention agenda sits in Government – not just between national and local government, the NHS and PHE, but across national government departments themselves. Only with improved accountability structures can we ensure a joined up implementation of the prevention approach through all public policy. One option could be for an explicit 'prevention responsibility' to be added to one ministerial portfolio in each department outside of DHSC.

[44] That Age Old Question, RSPH, 2018. https://www.rsph.org.uk/our-work/policy/older-people/that-age-old-question.html

[45] *Age in the Workplace: Retain Retrain Recruit.* Business in the Community.

1 – Online Harms

2 – Drug policy reform

3 – Air quality

A key example where greater integration of priorities would be beneficial is in the issues of loneliness and social connectedness, which both have a large influence on mental and physical health but are not fully addressed within the Green Paper. Similarly, the recent Online Harms White Paper has presented an excellent window for addressing issues relating to mental health, attitudes to vaccination, and much more. This is another opportunity for cross-departmental thinking, and for aligning the digital agenda with prevention.

Another public health issue where cross-departmental working is essential is around drug policy reform. RSPH supports the advancement of evidence-based harm reduction strategies in drug policy, and the rolling back of counter-productive criminal justice approaches which have been at best ineffective at reducing harm from drug use, and at worst responsible for exacerbating that harm. We are calling for an end to the criminalisation of people who use illegal substances, and for drug strategy and interventions to be led instead by government health departments. For more detail on the RSPH position, please see our report *Taking a New Line on Drugs.*[46]

A final priority for cross-departmental prevention policy is improving air quality. As discussed in section 11, reducing harm from air pollution is an urgent and often under-reported public health challenge, and it cannot be addressed without full buy-in from a range of different Government departments – most notably those working in environmental policy, transport policy, and planning policy.

The new Composite Health Index, as recommended by the Chief Medical Officer for England's 2018 report, and set out in the Green Paper, is very welcome. We urge the Government to take this forward and put together more concrete proposals for consultation. As a holistic tracker for the nation's wellbeing, and the potential for it to be used to evaluate the impact of wider government policies, it could be an effective way of giving other Government departments a stake in the prevention agenda.

14: Local action

While RSPH supports the integration of the prevention agenda into certain elements of secondary care in the NHS, the evidence demonstrates that for the majority of public health services, local authority delivery is effective, accountable and efficient. Since the transfer of public health to local authorities in 2013, the vast majority (80%) of indicators in the public health outcomes framework have shown either

[46] Taking a New Line on Drugs, 2016, RSPH. https://www.rsph.org.uk/our-work/campaigns/taking-a-new-line-on-drugs.html

no change or an improvement (with one exception being in aspects of sexual health[47]).[48] Considering the scale of cuts to local authority spending, these figures suggest that public health is most effective in the hands of local authorities and would significantly benefit from greater and sustained funding (see section 15).

15: Next steps

What other areas (in addition to those set out in this green paper) would you like future government policy on prevention to cover?

Alcohol

A key area that RSPH believes has been unduly neglected in the Green Paper is reducing harm from alcohol. Alcohol consumption is set to cost the NHS £17 billion over the next five years.[49] Liver disease deaths have increased by 400% since 1970, now the only major cause of death in the UK which is rising.[50] Alcohol consumption also plays a significant role in a wide range of social problems, particularly crime and workplace absence. The UK Government estimates the total cost of alcohol-related harm in England and Wales to be £21 billion per year.[51]

When it comes to policies for reducing harm from alcohol consumption, the alcohol industry has shown little willingness to make progress in the past. RSPH therefore believes that strategies that rely disproportionately on industry to implement changes are unlikely to make substantial inroads into addressing the scale of the problem.

We recommend that the UK government implement minimum unit pricing (MUP) for alcohol products for the rest of the UK. This should be set at 50p per unit initially, with built-in opportunities for review going forward. There is a significant and growing evidence base indicating that MUP is an effective tool for reducing alcohol related harm,[52, 53, 54] and moreover that it targets health inequalities because the greatest benefits are delivered to the heaviest drinkers and those living in poverty.[55]

We also recommend that the Government increase alcohol duties by 2% above inflation, and that this should be invested into alcohol treatment and prevention services. In addition, local authorities should be given more powers to control when and where alcohol can be sold. This could be done through

[47] https://www.gov.uk/government/news/people-urged-to-practise-safer-sex-after-rise-in-stis-in-england
[48] https://www.local.gov.uk/improving-publics-health-local-government-delivers
[49] https://alcoholchange.org.uk/policy/the-alcohol-charter
[50] Ibid.
[51] Home Office (2012) A Minimum Unit Price for Alcohol Impact Assessment. London: Home Office (pdf)
[52] Booth, A. et al. (2008) Independent review of the effects of alcohol pricing and promotion: part a – systematic reviews. ScHARR: University of Sheffield (pdf)
[53] Booth, A. et al. (2008) Independent review of the effects of alcohol pricing and promotion: part a – systematic reviews. ScHARR: University of Sheffield (pdf)
[54] Angus C, et. al. (2016). Alcohol and cancer trends: Intervention Studies. University of Sheffield and Cancer Research UK. (pdf)
[55] University of Sheffield (2015) – FAQ minimum unit pricing (website)

overhauling the Licensing Act, in a way that local authorities can then balance health and wellbeing priorities with potential licencees' interests.

Broader prevention services and funding

Effective prevention services need truly sustainable funding to enable local authorities to have the resources needed to address the specific challenges in their area. Many of the most effective evidence-based interventions for improving population health are already available to us, but have been forced to be either cut or reduced. This is as a result of persistent cuts and lack of investment, meaning that the current public health grant is £850 million lower in real terms than initial allocation in 2015/16.[56]

We welcome the real terms increase to the Public Health Grant budget in the September 2019 Spending Round, which will ensure local authorities can continue to provide prevention and public health interventions. This is a positive step in the right direction, but further detail is needed on what it entails. For example, it would be disappointing if the real terms boost were accompanied by and tied to the delivery of additional responsibilities for public health teams, thereby nullifying the budget increase. We want to see ongoing sustainable funding for public health services in next year's longer term spending review.

For more information on this submission, please contact Toby Green, Policy & Research Manager at RSPH, at tgreen@rsph.org.uk

[56]The King's Fund. *Health charities make urgent call for £1 billion a year to reverse cuts to public health funding*. 2019.