Written evidence submitted by Bedfordshire, Luton and Milton Keynes (BLMK) ICS (PHS0549)

Introduction

Bedfordshire, Luton and Milton Keynes (BLMK) ICS provides services and support to over 1 million people. We have strong relationships within the ICS and we are submitting a single paper from the NHS and Public Health perspectives to request the committee looks at embedding whole system approaches to prevention.

Submission

Action is required at national and local level to deliver against the DHSC policy paper 'Transforming the public health system: reforming the public health system for the challenges of our times' and the Fuller Report as the impact is greater when system wide and joined up. The ICS and work at Place (Local Authority) facilitates this locally, but we ask that the committee consider what cross-government action could be taken to prevent ill health. Examples include:

- The Fuller Report rightly cites in its vision a "more ambitious and joined-up approach to prevention". In reality delivery of prevention in primary care, such as NHS Health Checks and fitting of long acting contraception is variable, constrained by national staffing, estates and demand pressures. How can the government ensure that primary care is sufficiently resourced to deliver on the ambitions of the Fuller Report?
- Whether a cross-government mechanism is needed to ensure, where relevant, major government policies undergo a public prospective health impact assessment and a retrospective assessment after an appropriate length of time to ensure that these are preventative and reduce health inequalities. This is particularly important in departments leading on the wider determinants of health (i.e., housing, build environment, skills & education). If a 'health in all policies' approach is not taken then action in one area of government risks driving rather than preventing ill-health
- How national evidence-based approaches to regulation, taxes and other ways to disincentivise unhealthy behaviours and incentivise healthier alternatives can be better implemented
- The missed opportunities in the delay of Health Disparities White Paper and The Obesity Strategy and the lack of response to the Khan Tobacco Control review.
- Tackling local and regional health inequalities by investing in health creation is essential if we are to 'level-up' our left behind communities. How can this be brought to the forefront of the government's ambitions for levelling up?
- Whether behavioural insights approaches and social prescribing could be increased nationally recognising that many people don't have 'lifestyle choices', so focus on what we can do to support behaviour change for those with fewest resources – financial and resilience
- How planning law could be further strengthened to ensure that the built and natural environment facilitates physical activity and prevents the proliferation of fast food outlets, often concentrated in areas of higher deprivation
- Requiring a joined-up approach to prevention between the NHS and local government, for example, pooling of resources to deliver integrated weight management programmes rather than separate NHS and local government commissioned services.

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- Respond to and implementation of the Khan Review – really strong review but gone quiet and lacks strategic direction.
- Consistently think about proportionate universalism, appropriate resource allocation. We know it costs more to get the same outcomes in more deprived areas, with typically higher rates of smoking, obesity, alcohol, etc plus other inter-sectionality

Currently, we have individual programmes targeting smoking, obesity, physical activity, alcohol use etc., however, it is normal to see a mix of these conditions within a single individual. Both the NHS and Public Health have various programmes to tackle these issues, frequently with different metrics, reducing the potential for alignment.

These conditions are disproportionately prominent in lower socio demographic areas, again, the NHS and Local Authorities have programmes to reduce these inequalities that now work with far better alignment, but frequently have different metrics.

Finally, there is an apparent reduction in levels of self determination or personal responsibility for the prevention of ill health, although we recognise the significant pressure many are under that makes this challenging.

We propose that for many of these conditions there are similar causative factors, which lead to different outcomes (i.e., obesity or alcohol use) based on the individual and their environments.

We ask the committee to consider the use of a more holistic programme approach that targets reducing anxiety, while lifting feelings of hopefulness and self-worth, using measures such as ONS4 or SWEMWBS which are widely accepted. From this we believe that increases in wellness will be driven in cooperation between the patient/person and the health and care system, while minimising duplication or competition across programmes. Increasing the personal resilience of people may also present greater longevity of effect.

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