BUILDING HEALTHY COMMUNITIES

THE LOCAL LIBERAL DEMOCRAT APPROACH TO PUBLIC HEALTH

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STOPPING PEOPLE BECOMING ILL MUST BE OUR PRIORITY

More than 150 years ago my home city of Liverpool created yet another world first. It was the first city in the world to appoint a Medical Office of Health, Dr Duncan. It did so because attempts to stop cholera epidemics amongst rich people by improving the water and sanitation supplies had failed. Rich people kept dying. It was then understood that for rich people to be safe all people had to be safe. Diseases get transmitted easily amongst communities. Liverpool had to be made safe for all.

Our NHS system is under threat. Apparently it does not have enough money. That is true but putting more money into the NHS will only delay and not solve problems. If we are to help deal with the problems we need to do two things:

1. Stop people becoming ill. This is the public role of a total health system and is run by local government.
2. Get them home or at least into the community as soon as possible after they have been made well by the hospital system. This is the social care part of the total health system and again is run by local government.

By looking at these issues we can ensure that the hospital system, which sucks up about 70 per cent of the total NHS budget, can be run efficiently.

With up to 30 per cent of the beds in some hospital trusts occupied by people who no longer need acute medical intervention a huge number of beds could either be freed up or removed from the system entirely if we could get people home quickly. This costs money but not as much as hospital beds costs. Crucially community care is what our patients really want; at home in their community with their loved ones. This will be the subject of a further booklet.

This booklet is about public health. There is so much that can be and is being done by every council in the country. There are five horsemen of the apocalypse that cause a huge number of unnecessary medical problems. If we could deal with them there would be huge savings in cash and more importantly the misery caused by the conditions that are caused by them.

Those horsemen are well known:

- drugs
- alcohol
- excess sugar
- excess salt
- excess fat in foods.

To take one consequence of these, excess consumption of sugar and salt are the major causes of obesity. Obesity affects 30 per cent of 11 year olds in the country and anything up to 70 per cent of adults.

Obesity is a killer. Not on its own but because of the problems it causes with lungs, livers, hearts, kidneys, skeletal development, cancers and Type II diabetes. It has been estimated by the NHS that obesity alone costs the NHS £5.1 billion each year. That is twice the 2015/16 deficit on the health service.

Dealing with these issues does not involve new research; equipment or vast sums of money being spent. It needs:

- more work being done in the community with individuals to help people understand the consequences of their actions in terms of their health
- concerted effort to change the health culture to enable people to take more responsibility for their own health lives
- changes in legislation to ensure higher standards in food and drink
- more work by the council and NHS working together community by community to develop appropriate community based responses to change the cultures which collectively cause ill health.

It can be done. Tobacco consumption is 25 per cent of what it was 50 years ago. Binge drinking is showing a sharp downturn amongst the young, though not amongst the wine drinking 'responsible' middle class where it is on the increase.

This booklet sets out some essays which show what can be done within communities and comes up with some policy recommendations for both local and national government.

It is not designed as an encyclopaedia of good practice but as a starting point for Lib Dems and others to engage in their councils; in their communities and in our party to make sure that public health and its solutions becomes a key way of saving the NHS and more importantly preventing the illnesses which are caused by unhealthy and over-plentiful food and drink accompanied by lack of exercise.

Let's start raising these issues in every council chamber in the land.

Councillor Richard Kemp CBE

Liberal Democrat Spokesperson on Social Care and Health

Local Government Association

Vice Chair LGA Community Wellbeing Board

Councillor Wendy Taylor

A NEW LOOK AT PUBLIC HEALTH

With money so tight, councils need to look at innovative ways of improving health for our communities. There are some quick wins that don't cost a lot of money and also ways of creating new partnerships that may bring in funding from other sources. I want to discuss two initiatives that have the potential to make a big difference.

A mile a day

Earlier this year I heard a discussion on Radio 4 about an initiative that started in a small school in Scotland. For three-and-a-half years, all pupils at St Ninian's Primary School in Stirling have walked or run a mile each day. They do so at random times during the day, apparently happily, and despite the rise in childhood obesity across the UK, none of the children at the school are overweight.

Not only has it done so much to improve these children's fitness, but behaviour and concentration in lessons has also increased. It seemed too good to be true. However one in 10 children are obese when they start school at the age of four or five, according to figures from the Health and Social Care Information Centre, and this summer one study suggested that school children in England are the least fit they have ever been. So if the 'Mile a Day' works, it really is a simple way to change these statistics. Already the initiative has been cited in the National Childhood Obesity Strategy.

I'm a governor of my local primary school, so I asked if the school would like to give it a try. The staff reacted enthusiastically and the Mile a Day was introduced.

The children all walk/jog/run for 10 to 15 minutes per day. The headteacher tells me that they have probably only missed about six days since September because of poor weather, which shows the level of staff commitment.

Staff have found a steady improvement in fitness levels for a significant number of children, particularly in terms of the proportion able and willing to jog for the full session rather than walk for some or all of the time. There have been particular benefits for some children who have always been reluctant to get involved in physical activity, but are now far better motivated and able to join in because of improved fitness. One young boy with mobility problems was cheered on one day by Year 6 pupils waiting to go on an outing and this really motivated him to succeed.

Staff have also found benefits in terms of children's concentration levels, particularly in the afternoon when the run has taken place at some point during the afternoon session.

Every primary school could introduce this, so if you're a school governor, persuade your school to give it a go and see the positive benefits.

Parks and leisure centres as a focus for health and wellbeing

Like most councils, Newcastle is struggling to maintain our parks, yet they should be playing a central role in improving fitness and keeping residents healthy. Our Director of Public Health, Eugene Milne wants to look at parks across the city to see how they could be used for both primary and secondary prevention. By working with different partners in different parts of the city, he's come up with some exciting ideas.

1. There is an almost derelict building in a park near the centre of the city close to a large hospital. We also have a charity that has been offered a large grant for a drug and alcohol recovery programme and is looking for a building. Talks are now ongoing with Public Health England (PHE) and the Heritage Lottery to see if this building could be brought back into use as a mental health unit to provide the recovery service. The building benefits from not being too close to housing, but is close enough to work places such as the hospital and our new Science Central complex that a bakery and café on site could provide those using the service with a chance for work experience.
2. The council decided last year to close a swimming pool in one of the most deprived areas of the city. When the Liberal Democrats took control of Newcastle Council in 2004, we helped local residents take over Fenham swimming pool that had also been earmarked for closure by the previous Labour administration. That pool is still open. In the case of Elswick pool, local residents are also keen to keep their pool open, but it is more difficult to come up with a realistic business case. Possible ideas to help are being investigated. Discussions are ongoing with a local GP practice to use the pool and nearby park facilities for social prescribing, encouraging those at risk of heart problems for example to be involved in a structured exercise programme at the pool. It might be possible to get a grant from Sport England and to set up a community interest company. One option might be for the GP practice to move into the pool building.
3. Other organisations may be willing to provide funding for parks. The Lawn Tennis Association is keen to redevelop courts and increase training. The Football Association want to invest in high quality 3G pitches. The key for all these approaches is to make better use of the public estate by bringing services together. With increasing use of the parks, other facilities such as cafes become viable.

4. The NHS Sustainability and Transformation Plans (STPs) are attracting a lot of adverse publicity due to the unrealistic financial savings that have to be included, but the plans can also be used to push for more to be spent on preventing ill health and reducing admissions to hospital. Our local STP includes a promise to provide funding for secondary prevention for 20,000 patients across Newcastle and Gateshead by 2020/21. This could include patients with diabetes, heart problems, knee injuries and mental health problems, for example, who would be prescribed a 12 week course of exercise as part of their treatment. There is already good evidence for the success of this approach and assuming around £300 to £400 per patient, this could provide income for leisure centres, swimming pools and parks to help keep them open and well maintained.

All these ideas are work in progress and some may not work out, but as funding becomes ever tighter, it is important for councils to share ideas and come up with innovative ways to keep our residents fit and healthy and reduce inequality.

Dr Wendy Taylor has been a Liberal Democrat Councillor in Newcastle for nearly 30 years. She is Deputy Leader of the Lib Dem Group and is currently Chair of the Health and Wellbeing Scrutiny Committee. She was previously the Executive Member for Environment, Sustainability and Transport and works as a hospital consultant treating breast cancer.

HIV Testing Week in London Borough of Sutton

National HIV Testing Week takes place every year in November leading up to World Aids Day on 1 December. Sutton Public Health organised a series of community HIV testing initiatives throughout the week via mobile apps, social media and a billboard poster display at Sutton train station.

Advertising via mobile apps allowed us to target our most-at-risk groups. We placed advertising on the dating app Grindr, used the agency xAds (which targets 70,000 popular apps) and Facebook, which included a video of the leader of Sutton Council having an HIV point-of-care test in a local library. This video was viewed in total 8,020 times over Facebook and Twitter. The video included details of where and how easy it is to have a HIV test.

The local community HIV testing service saw an increase of walk-in test requests of over 300 per cent and there was a 440 per cent increase in the amount of HIV home-sampling kits requested during the week. Through all advertising avenues this resulted in 579 click throughs to further information on how to get an HIV test.

GP registration for offenders

Public health in Sutton are currently involved in an innovative collaboration with NHS England and the probation services. The scheme involves 27 GP practices in Sutton which are part of a pilot scheme which has now been extended to all London boroughs.

People entering the criminal justice system often have long-standing, complex health issues. Having a long term mental health condition can be a significant risk factor for the development of physical ill health and vice versa. Physical health problems are often not diagnosed or managed efficiently and lifestyle factors can negatively affect physical health. The outcomes for both the resettled ex-offenders and the local communities have far reaching effects both for the individual's health and reductions in reoffending rates.

There are about 36,000 people under probation supervision in London each year. Unique features of the scheme are:

- ability to use probation premises as a proxy address
- arrangements for prison healthcare staff to check and record a prisoner's GP status
- the London prisons computer system (SystmOne) is being upgraded to allow GP access to patient notes held by prison health care teams.

Elizabeth Wade, Director of Policy, Pharmacy Voice

LOCAL PHARMACIES AND PUBLIC HEALTH

It's safe to say that 2016 was a difficult year for many. Local authorities up and down the country had to make increasingly difficult decisions; forced to find ever more creative ways to makes ends meet, in the midst of reduced government funding and the relentless pressure placed on them by ballooning demand for adult social care services. Similarly, 2016 was a challenging time for community pharmacy providers, with swingeing cuts to our NHS funding imposed by the Government, putting many of the vital services we provide at risk.

What is at stake here includes the broad social capital and value we bring to local communities – not only through the dispensing of vital medicines but also by providing effective health advice and support to people managing long-term conditions or with urgent care needs, as well as essential public health services such as smoking cessation and weight management. Local pharmacies are important community assets too – driving footfall to high streets and offering social contact and support in more isolated areas, while providing skilled and highly valued jobs to local people.

One of the ways we see community pharmacy developing in 2017 is by pharmacy teams working more closely with their partners at the local level, to ensure their existing value and future potential is fully realised.

Community pharmacies are ready and willing to help in tackling some of the big public health challenges facing local government.

They are ideally placed to do this, through their role as local community health and well-being hubs – after all they're more accessible than GP surgeries, open longer hours and available without an appointment, and asking to take on more work.

Perhaps most importantly, community pharmacy teams are able to interact with people opportunistically, providing health messages and advice to those who might not access other health services and making brief interventions that can make a big difference to health behaviours and lifestyle.

Our vision is for community pharmacy to become the 'go-to' destination for support, advice and resources on staying well and living independently.

As a trusted local community resource, all pharmacies would be connected with other organisations that promote health, wellbeing and independence – ranging across local community groups, charities, places of worship, leisure and library facilities, social care, education, employment, housing and welfare services – and able to refer and sign-post people to them.

Community pharmacists and their teams would work closely with employers to support workplace health initiatives, and would help people make best use of the data, technology and devices they use to monitor and manage their own physical and mental health and wellbeing.

This is an idea that has support from the wider health community. The Royal Society of Public Health's (RSPH) 'Health on the High Street' and a recent PWC report into the value of community pharmacy both talk about the important role pharmacy teams play in delivering efficient, effective services that help improve health outcomes.

Despite the setbacks we have faced in 2016, the sector's ambition to play a greater role in the delivery of primary care and public health services remains. In August 2016, Pharmacy Voice and PSNC, with the support of the RPS English Pharmacy Board, released our cross-sector vision for the future of community pharmacy. The Community Pharmacy Forward View (CPFV) sets out the sector's ambitions to radically enhance and expand the personalised care, support and wellbeing services that community pharmacies provide. In the scenarios outlined in the report, pharmacy teams would be fully integrated with other local health and care services in order to improve quality and access for patients, increase NHS efficiency and produce better health outcomes for all.

The Forward View outlines three key roles for the future of community pharmacy:

- as the facilitator of personalised care for people with long-term conditions
- as the trusted, convenient first port of call for episodic healthcare advice and treatment
- as the neighbourhood health and wellbeing hub.

This shared vision is the first of its kind in the community pharmacy sector and, if realised, would represent an enormous leap forward for the public health and health care system. Much of what is proposed would need to be commissioned and delivered on a local level and will require close working between community pharmacy teams, local authorities and their partners, as well as action from community pharmacy leaders, the Government and national NHS bodies.

To help embed and support these relationships at a local and national level, we have now launched the next stage of the Forward View project: Making it Happen. In this latest publication we introduce an implementation framework, outlining pathways for the policy change, professional development and the partnership working required to enable community pharmacy to play its full role within an integrated health and care system.

We also call on colleagues, including those in local public health leadership roles, to make a commitment to work collaboratively with the community pharmacy sector, so we can design and create this future together.

Achieving these aspirations will take a concerted effort and significant consultation and engagement. We really welcome your views on the Forward View and outline implementation framework; please visit www.cpfv.info for more information.

As we enter 2017, one thing is certain: to realise the opportunities and aspirations we have for supporting our communities. Local authorities, community pharmacists and their teams need to work much more closely together. The LGA was highly supportive of the national campaign to back community pharmacy during 2016, recognising the additional pressure that funding cuts to pharmacy could place on local authorities and the people they serve.

But it is at the local level where partnerships can have the biggest impact. That's why we would encourage you to reach out to your local community pharmacy providers and ask how your authority might work more closely with them, to maximise their contribution to public health improvement.

A good way to do this is to contact your Local Pharmaceutical Committee (LPC); you can find the details of your local committee by visiting here http://lpc-online.org.uk/

Elizabeth Wade joined Pharmacy Voice as their first Director of Policy in February 2014, and is responsible for leading the organisation's policy research, analysis and influencing activities. Elizabeth has a background in health service management, research and policy, with particular experience and expertise in primary care development and commissioning.

Councillor Stewart Golton

SOCIAL ENTREPRENEURSHIP AND THE 'CIVIC POUND'

The current headlines about how we will manage to care for our increasingly elderly population are dire. The LGA has warned that councils will simply not be able to deliver social services as well as empty the bins at the current level of municipal cuts.

Despite the efforts of the likes of MPs such as Norman Lamb and Liz Kendall, the prospects of producing an all party consensus to find a centralised solution to funding are as far off as ever. The arrival of Brexit not only places an added financial pressure but also distracts from focusing on transforming care delivery as Whitehall concentrates on drawing up the Great Repeal Act.

Nevertheless, it is precisely at this point that local authorities can make the difference that could create the environment for truly transformational change of the delivery of care within communities. Even without signed and sealed devolution deals, billions of spending on care and health services are controlled locally already, and it is up to politically led councils to show leadership to ensure their 'civic pound' achieves its best value.

The introduction of health and wellbeing boards (HWBs) in each local authority has already had an impact on developing models to align and pool budgets controlled by councils and NHS bodies, and the safeguarding agenda has knitted local police and fire services into that local joint budget setting model. This is where the 'civic pound' sits, in the tax payer funded public bodies and agencies. As each of these budgets come under even closer scrutiny through austerity-led reviews, the opportunity for councils (the only electorally accountable body) to better influence how that money is spent, and deliver better outcomes, is huge.

So how could the civic pound be invested differently to respond to the health and care crisis and support key priorities such as new care models based on the needs of patients?

Councils are increasingly withdrawing from directly delivering social services, and instead leave the delivery to the 'independent' sector. This can involve the voluntary sector, but more of often than not, particularly in residential settings, it is the private sector that is expected to fill the gap.

Turning to the private sector can deliver better value by improving productivity, however, the private sector now offers diminishing returns, and is itself becoming fragile, with homes closing.

My own Labour-run local authority recently divided its home care service into six area contracts that were offered to the 'independent' sector. Only one contract went to a social enterprise, and even that was a business based 100 miles away. The rest went to national and international conglomerates.

These contracts may have added up on paper, but were they a good use of the civic pound? How much of that civic pound was retained within the local economy? Did it contribute to developing place based leadership and strengthen the local care market?

Local STPs are meant to be developing place based systems of care, moving away from traditional commissioning that rewards according to numbers of patients seen or treated, or care packages delivered. Instead the future will increasingly see the development of capitated budgets that focus on the health needs of an entire population, and will therefore need to focus ever more on prevention.

New models of care are meant to focus on the needs of the individual, with people more involved and in control of their own care, and for that care to be delivered as close to home as possible, with professionals integrating better to achieve this.

How can the civic pound be better spent to reach this goal? The simple answer is to proactively enable communities to step up and respond in the interests of themselves and their neighbours. Local authorities are uniquely placed to encourage social entrepreneurship within communities to manage the risks local councils themselves face.

The problem is that many councils have not developed their own capacity to innovate to achieve this.

I have had experience of this in the ward that I represent. In response to two outdated council care homes facing closure, a local trust formed that wished to build a new residential home as a social enterprise. They also had as a financial and business guarantor a current social enterprise residential care provider operating in the Midlands.

Although initially supporting the proposal, after four years of procrastination, the council withdrew their support when they heard a private sector operator planned to develop in the area. They duly opened offering "five star luxury accommodation for the discerning client".

My community now has a facility that most will not be able to afford, and whose profits go elsewhere. The social enterprise that was proposed had a business plan that offered more affordable beds, but also wanted to offer day care, respite care, and act as a centre for a home care operation that the private facility does not offer. The profit would have been recycled into the business, council staff would have been transferred, and the trust was to have developed community links.

The irony is that the council has experience of supporting and enabling community social entrepreneurs when they are called school governors, and they are used to enabling land deals to encourage retail and business growth, but did not have the imagination to do the same kind of enabling to help the community respond to the area they face the biggest challenge in.

The enabling of community based social enterprise through the civic pound is not just economically more progressive, with no profit being topsliced for shareholders outside the community, and the management fee staying in the local economy, it also adds value. A locally based organisation could also be trusted to more effectively engage with the correct networks through local knowledge. A more locally accountable care provider can also better respond to the churn in care staff turnover by reducing travel time, investing in staff skills-based rewards and offering flexible working.

More importantly, a locally based care provider can offer more effective prevention-based partnership working with local GP practices and pharmacies, and be more responsive to the needs of a local care market than a private firm with a modus operandi set elsewhere.

Finally, in the context of Brexit, when the politics of identity are more salient, that sentiment can be focused on encouraging wider participation in a progressive enterprise in our own local community where people feel more in control of their own future wellbeing.

Stewart Golton is the Leader of the Liberal Democrat Group on Leeds City Council and also a member of the Leeds Health and Wellbeing Board. Stewart is an LGA member peer with experience in reviewing health and care integration and has encouraged social enterprise delivery of adult care within Leeds.

Councillor Jerry Roodhouse

TRANSPARENCY AND OPENING UP THE HEALTH SERVICE

How many times have you heard or even been involved in stories that involve health services denying information? In my experience they include individual cases where a loved one with sepsis and related medical complications has passed away and you're not satisfied with what you have been told – only to be informed that they cannot divulge information because of patient confidentiality even to the partner that is left alive – through to all the NHS consultations that take place on changing service provision.

As a population we are encouraged to trust that the health professionals know best and that we should not question them. Governments over time have brought forward new ways of ensuring patients' voices are heard and we now have the latest version called Healthwatch. With patient advisory liaison service (PALS) and advocacy services it is of no surprise and no wonder that groups and individuals are confused.

Running alongside this are the clinical commissioning groups (CCGs), HWBs and local authority health scrutiny bodies all producing reports and changing services. Plenty is said and plenty of reports are produced. We have loads of evidence which has been placed into the public arena but what change has taken place in ensuring that the patient's voice is really heard?

And what has been done in adopting those recommendations that will allow the extra transparency that the NHS needs?

The NHS needs to change – it must become more open. What could we be doing now? Especially if you are in an elected position or any position of influence. The system can be loaded against the individual and as said it has a long history of not divulging information and of not being transparent. The NHS Constitution gives us the baseline from which to develop a more meaningful policy in this area.

There are a number of approaches that we should look to develop:

- individuals
- NHS local systems CCG
- NHS Trust (acute hospitals and mental health trusts).

Individuals

As an elected councillor I know that I am in a unique position to help support and navigate individuals around complex bodies from local authorities to NHS bodies. Councillors should be able to support and help an individual through the complexities of care and health systems. Extra support should be made available to elected members in order for them to understand the system and support the casework they have to handle.

The LGA and Liberal Democrats should be pressing government so that health scrutiny is given the extra power to call NHS England representatives to appear at local hearings – bringing about greater accountability.

Local systems (health economy)

HWBs' performance varies across the country but we need to remember that they have statutory duties. These boards should always be held in public with minutes and reports placed in the public arena. All the key players should be sat around the table including Healthwatch. The first test is how accountable are they in the production of their strategy. Do they engage fully with local communities?

There is still a gap between the emerging STPs and local health and wellbeing strategies and the public – why is this? I suspect because the STP process is driven by NHS England and is not a community led process. It is left to professionals with the proviso that we will consult you when the time is right. All the planning has been done behind closed doors waiting for clearance from NHS England. Only then would the public consultation start if needed.

There is also confusion as to who should be holding who to account, Health Scrutiny, Care Quality Commission (CQC) or HWBs themselves.

The system needs to made more efficient and streamlined so that as an individual patient/citizen it is clear where and who is doing what. We need to see single point of entry and accountability.

NHS acute trusts and mental health trusts

I am reminded of the time when I chaired the Health Scrutiny Committee and we had set up a meeting with the chief executive of an acute trust only for it to be cancelled at the very last minute because he had been called to DH in London.

This happened on numerous occasions. It is clear that trusts see their bosses and who they report to as DH with no regard to the localities they have to serve.

For example, the Patient Advice and Liaison Services (PALS) as they are known are based within the trusts and vary tremendously. Health Scrutiny could be calling in PALS' service and holding them to account.

Local government could be lobbying for set of standards for PALS, and for funding arrangements to be reviewed. The patient needs to be able to trust the independence of the organisation.

Conclusion

I have endeavoured in this paper to briefly outline the increasing pressure for opening up a system that is at this time not fully accountable.

There is a growing demand on services and the finical pressures will grow. It is not going to be easy and we will need to work together openly to find ways that are better – talking with communities not at them.

Councillors can help residents to navigate the system. I am reminded about the elderly gentleman who had dementia, was taken into hospital and left without water or food until a local councillor who knew him went in with his elderly wife. They found out that his false teeth had been lost and when the councillor wanted to engage the trust about finding solutions the shutters were brought down – surely this culture needs to change?

If the system at all levels is to change it has to be become more open and transparent and with that comes accountability for its actions.

For me that can be done at a local level by local government taking the lead – after all councillors are truly democratically accountable. This journey will not end as change is an ongoing journey and is always around the corner but the journey of gaining greater transparency and openness has a long way to go.

What we need to see is a new modern simple and clear patients' charter that is enshrined in law and a new refreshed NHS constitution that is fit for the next generation. Sounds like a campaign to me.

Jerry Roodhouse is a long-standing councillor on Warwickshire County Council and Rugby Borough Council.

He has chaired Health Scrutiny Warwickshire, the Warwickshire Local Involvement Network (LINK) and is currently a director of Warwickshire Healthwatch.

Councillor David Harrison

HEALTH AND NATIONAL PARKS

I am the Liberal Democrat Opposition Spokesman for Health and Adult Services on Hampshire County Council but I am also a very enthusiastic member of the New Forest National Park Authority.

Since I was a small child, I instinctively understood the benefits of getting out into the New Forest, often on my bike and enjoying the great outdoors.

Now I am all grown up and sophisticated, I am seeing, in a more formalised way, research evidence that demonstrates just how important nature is to our wellbeing. The phrase being bandied about by educated people is 'ecosystem services'. This simply means goods and services which are the many life-sustaining benefits we receive from nature – clean air and water, fertile soil for crop production, pollination, and flood control.

I am especially fond of our National Parks, sometimes referred to as our 'breathing spaces'. It's incredibly important that we keep these areas as special, restricting inappropriate development and protecting them for future generations to enjoy.

A friend of mine describes the New Forest as his psychologist. He finds spending time in the area helps him deal with stress and recharges him. I know exactly what he means.

National Park Authorities are one of the few areas of local governance that have seen a reasonable five year settlement from central government. It is to be hoped that, whichever government is in power, the value of the parks and the authorities charged with looking after them are recognised.

One important aspect of what National Park Authorities do is reaching out, beyond the borders of the parks, engaging with communities and supporting projects that help improve nature, even in the nearby towns. In the New Forest, we are calling it the Green Halo. It springs from a recognition that nature can best be supported by carrying out environmental work all around the borders of the park, as well as in the park itself.

I live just outside the New Forest, on the edge of the city of Southampton. This has serious air quality issues that must be tackled. I have been pressing the case for restricting car use, improving public transport options and even things like park and ride.

I am even leading a campaign for the restoration of a passenger train service that will run along the edge of the New Forest.

I am very sure that not all I want to achieve will be completed in my lifetime, but I have already seen some major successes, seeing off some harmful developments and introducing a new walking and cycle route in my county division, as well as a brilliant New Forest Bus Tour (do check it out if you come for a visit).

I suppose most of us are happy with where we live but perhaps can also see that it could be improved, especially for nature. If you want to make a difference, getting involved in local politics can be a great way of doing so. Please visit my Facebook page for more information.

David Harrison is a town, district and county councillor, representing part of the New Forest in Hampshire. He is an enthusiastic supporter of national parks and is chairman of the Resources, Audit and Performance Committee on the New Forest National Park. He is also leader of the New Forest District Council Liberal Democrat group.

Councillor Claire Young

TRANSPORT AND THE RURAL DIMENSION TO HEALTHCARE TREATMENT

According to the Government's 'Rural proofing guidance', 21 per cent of rural households have to travel 2.5 miles or more to access their nearest GP surgery and other health services can be several miles away. The population is generally older than in urban areas and in the most rural areas only 42 per cent of households have a regular bus service. The situation has worsened recently as weekly GP surgeries in villages have been cut.

If accessing primary care is difficult, the challenge is even greater when it comes to secondary care. There has been a trend in recent years towards centralising services in larger hospitals. While it is argued that consolidating acute care into fewer, specialist centres improves health outcomes, it also makes it harder for people to access the services. Even in South Gloucestershire, where only about a fifth of the population lives in a rural area and it is on the doorstep of a major city, up to 13.5 per cent of the population have to travel for over 60 minutes by public transport during peak times to get to their nearest secondary care provider.

For many people in rural areas with cars, the challenge can be getting to appointments at peak traffic times, the lack of parking on arrival and the high cost at many hospitals when it is available.

All these issues cause anxiety and stress to patients and disrupt hospital administration due to late arrivals and missed appointments.

For those who don't have cars or whose condition or treatment prevents them from driving, the lack of rural public transport is a serious problem. When a new facility is provided, there may be an opportunity to secure money through a planning agreement, but even if this can be negotiated it will be time-limited. Commercial bus operators claim that it is difficult to make a service that primarily serves a hospital commercially viable and the pressure on local authority budgets has drastically reduced subsidies to rural bus services.

Even where there are services, a long bus journey involving multiple changes, often at bus stops without adequate shelter, may be too much for a patient. Visitors are likely to reduce trips to see friends and relatives, which is detrimental to patient recovery.

Although in theory transport can be provided by the NHS to a limited number of patients who qualify, many people are unaware of this and are not offered it. GP surgeries frequently refer people to the over-stretched community transport sector rather than offer hospital transport from NHS budgets.

South Gloucestershire Council, having recognised the rural transport gap, developed a bid for the Total Transport Fund. Officers wanted to establish the capacity of the local community transport operators to help the NHS transport patients and visitors from the rural areas.

They also wanted to see if the NHS appointment making processes could be changed to help patient transport. In March 2015, they received £150,000 from the Total Transport Fund and have already carried out a review to establish what the current issues are in detail.

They are now working on stage 2, continuing the consultation with transport operators such as Community Transport, Voluntary Transport, taxi operators, the Patient Transport Service (PTS) and stakeholder groups. This will deliver a comprehensive feasibility study.

Relying on volunteer-run services has obvious pitfalls though. Often a volunteer-run service depends on one or two key volunteers, without whom the service may rapidly disappear. Some Community Transport services have paid administrative staff to coordinate bookings and may have access to a computerised booking system.

Others do not. In South Gloucestershire they are looking at whether the software system used by the PTS for scheduling could be shared with the voluntary sector groups, but do they have the expertise to use it? Who will pay for the software licences? What will happen when the PTS service is re-tendered and potentially a new provider brings with them new software?

The timing of appointments can make a big difference to how easy it is for a patient from a rural area to get transport. Locally people report that even when they have requested appointments at a particular time of day, their requests have been ignored.

Rather than always focusing on getting people to the services, more could be done to bring services closer to patients. The Bristol Health Services Plan 2004, which led to the closure of Frenchay Hospital in South Gloucestershire, included taking more outpatient services out to the community.

The health service appears to have been backtracking since then, claiming that they need a critical mass at each clinic to make it financially viable. However, anecdotally it appears that patients are not being made aware of more local options and in some cases are still being referred to the main hospital by default. Little surprise then that not enough people have been using the local clinics.

In Yate, South Gloucestershire, there is a medical centre that not only includes a minor injury unit, but also offers x-rays and outpatient appointments. Changes in service delivery can take some time to be recognised by the public but uptake has improved as public awareness has increased.

The opening hours of the minor injury unit and xray facility could be improved and it sometimes closes early because of lack of capacity. Proper funding and promotion of these services would help reduce the number of patients travelling to the major hospitals.

The South Gloucestershire Clinical Commissioning Group is currently running a two year pilot of minor injuries services at GP surgeries. This could help bring services even closer to patients but again, you need to know the service is there to use it. Both their website and their smartphone app directs you to the minor injuries units for minor injuries, not GP surgeries.

Taking a more high tech approach, there may be potential for more telehealth services so patients don't even have to leave the comfort of their home. However this will require fast broadband services in our rural areas.

People living in rural areas clearly face significant difficulties accessing health services, a situation that is worsening as they become more centralised. Tackling this problem has to involve more than putting ever more pressure on stretched voluntary services.

Claire Young is an experienced councillor for a largely rural ward and the Liberal Democrat Parliamentary Candidate for Thornbury and Yate. Deputy leader of the Liberal Democrat group on South Gloucestershire Council since 2011, Claire leads for the group on Environment and Community Services issues, a brief covering a wide range of services including transport.

Dr Clare Gerada

EXPANDING THE ROLE OF GPS IN COMMUNITY HEALTH

"The roles for GPs are increasing. Every consultation is an opportunity to detect early-warning signs that prevent illness and disease. Sensible, timely and appropriate interventions can help make people aware of the potential risks they are taking." (Field 2010)

I am a general practitioner, and have been since 1991. I have in the most part worked in South London. My main practice is a large health centre located in the bottom two stories of a 17th storey block of flats. Our patients are literally on top of us and the practice is integral to the local community it serves. As such I hope that I do more than just deliver health care.

The practice is a hub for healthy eating initiatives, local groups meet in it (including over recent years AA, patient groups, mother and baby groups) and we share an active patient and public participation group with the local library. Issues that affect my patients and my communities' health and wellbeing, such as the closure of the library, the removal of a pedestrian crossing or the fate of our local Sure Start service and poor housing affect us all and together we work to address them through the relevant bodies. This is the essence of public health and I am, in being a local GP, immersed in my community, supporting its delivery alongside all the other roles I play.

In recent years I have worked in another area of South London which London gentrification has largely left behind. The area is marked by social deprivation, poor health and low employment rates – which have not changed much in the last century. The practice is within a stone's throw from an innovative project which began now nearly 100 years ago, called the Peckham Experiment. It started in 1926 and ended in 1950 and was initially created due to the concern over the health of the working class and an increased interest and knowledge around preventative care.

Two doctors opened the Pioneer Health Centre in a house on Queen's Road SE26 where local residents, at very low cost, could have access to a range of activities including a swimming pool, workshops, as well as access to health care. By improving physical activity, providing mothers with help in addressing their babies' health and by providing physical spaces for people to meet and socialise, in a building delivering health care was groundbreaking at the time.

Like me now, these doctors considered their role as going beyond the confines of the consulting room, beyond the presentation of acute illnesses and beyond dealing only with the 'here and now'.

Their role as that of the modern GP is about addressing the causes of ill health and where possible removing or reducing their impact. Nowadays a GP's role is a mix of addressing immediate and necessary treatment (coughs, colds, infections), managing long term chronic health conditions (diabetes, dementia, depression) and helping patients stay healthy for as long as possible through a range of preventative strategies (including immunisations, screening, promoting healthy lifestyles).

General practice is now a key plank in any public health strategy. GPs are ideally placed – seeing over 1.4 million patients per day, to provide not just acute care but also to promote health and wellbeing of their patients. This might be in the form of health promotion – about giving patients advice that encourages a healthier lifestyle, giving practical help to address smoking or excess alcohol use, or perhaps talking about healthy eating. Effective health promotion can prevent or lessen the effects of certain lifestyle diseases, such as diabetes (type 2) or heart disease. There is evidence that when a GP offers brief advice about the harms caused by smoking cigarettes that this results in a reduction in smoking – sometimes only five minutes with a GP can change this behaviour.

Primary prevention

This is about reducing the amount of an illness in a population and thus to reduce (as far as possible) the risk of new cases appearing, and to reduce their duration. For example, preventing people starting smoking by health education in schools will reduce the number of people getting lung cancer years later. Immunising children against measles, mumps and rubella will decrease the incidence of these infections in the population, and with diseases such as polio might eradicate it all together.

Secondary prevention

This is aimed at detecting and treating pre-symptomatic disease. For example, cervical screening.

Tertiary prevention

This aims at reducing chronic incapacity or recurrences in a population, and thus to reduce the consequences of an illness. This might involve helping patients with diabetes lose weight or ensuring they attend for regular eye checks to prevent blindness.

Since the Peckham experiment there have been many more examples of general practice becoming involved in addressing public health and preventing ill health in deprived communities. Since the 1970s the Bromley by Bow Centre in East London has been providing community services to its local population.

This centre supports families, young people and adults of all ages to learn new skills, improve their health and wellbeing, find employment and develop the confidence to achieve their goals and transform their lives.

At the core of the centre's thinking is their "belief in people and their capacity to achieve amazing things."[1]

Another example of how GPs can help to improve their patients' health is through working with non-health community partners. For example, the Liverpool Healthy Homes (LHH) initiative seeks to prevent premature death and avoidable illness due to poor housing conditions and accidents in the home.[2]

It is an example of community-orientated primary care (COPC), described by a GP, Steve Gillam as "the continual process by which primary health care teams provide care to a community on the basis of its assessed health needs by the planned integration of public health with (primary care) practice," aiming to:

- tackle health inequalities, caused by poor quality housing conditions
- remove health and safety hazards from homes including excess cold
- engage residents on their doorstep and in their own homes, identify and support those most in need in our communities
- provide advice, promote health and awareness of the health impacts of poor housing conditions and accidents within the home.

GPs have an increasing responsibility to prevent illness and improve health, and indeed there is an enormous potential for general practice to take a much more proactive role in ill health prevention and public health – if only we had the time, space and resources to do more.

Working in partnership and integrating ill health prevention into the GPs' current work will help to make public health policies more sustainable. Local councillors and GPs are very similar. Both of us hold surgeries, engage with community leaders, address the causes of distress and try and reverse them and are fundamental to improving the health and wellbeing of the people we serve.

1 http://www.bbbc.org.uk/#sthash.nrgX9PrV.dpuf

2 www.liverpool.gov.uk/Environment/ Environmental health/healthyhomes/index.asp

Providing proactive ill health prevention must be done in partnership with wider GP teams and with their local community, including health, housing, local councillors and others.

Since 1991 **Clare Gerada** has worked as a GP in South London. She has established services for the homeless, drug and alcohol users and the mentally ill. She divides her time between general practice and heading up one of the largest practitioner health (sick doctor) services in Europe. She is committed to the NHS and sees it as the best way of delivering fair, universal and cost effective health care.

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Norman Lamb MP

MENTAL HEALTH AND PUBLIC HEALTH

At the start of the new year, the Prime Minister vowed to "transform the way we deal with mental illness in this country at every level".

She spoke powerfully about tackling the "burning injustice" of inadequate support for people who suffer from mental health problems, with a welcome emphasis on early intervention and improving access to treatment for children and young people.

But despite her encouraging rhetoric, I was struck by how little we heard about the importance of preventing mental ill health. Disappointing though this was, it reflects a national blind spot that threatens to undermine not only the mission to arrest Britain's growing mental health crisis, but also our wider public health objectives. As a country, we simply haven't treated prevention in mental health with the same seriousness as in physical health.

Public health strategies are underpinned by the principle that prevention is better than cure.

Resilient in the face of funding cuts, councils have continued to provide a wide range of services aimed at improving physical health and preventing illness in their communities, including interventions to combat smoking, obesity, inactivity and STIs.

However, public mental health has too often been neglected. Data obtained by the charity Mind shows that local authorities are spending, on average, less than 1 per cent of their public health budgets on preventing mental health problems.

The proportion of public health budgets spent on mental health has fallen over the last three years, from 1.4 per cent in 2013/14 to just 0.7 per cent in 2015/16. And last year, 13 local authorities spent nothing at all on public mental health.

Given that mental ill health affects one in every four of us and accounts for around 23 per cent of the national burden of illness, this is both morally wrong and totally irrational. The effects of mental ill health can be devastating. It impacts on all parts of a person's life including their education, employment, physical health and relationships, costing the economy an estimated £105 billion every year in healthcare costs, welfare payments and lost productivity.

In light of these far-reaching effects, what justification can there be for failing to invest in saving people from a lifetime of misery, unemployment, and broken relationships? We know that prevention works. It avoids illness, keeps people in work, and relieves the pressure on healthcare services.

By spending such a paltry amount on preventing mental health problems, we store up massive problems later down the line.

Councils should see mental health as central to their public health strategies. If we are going to get serious about prevention, these strategies must contain clear measures, promoting good mental health and resilience in their local communities, along with a year-on-year increase in the proportion of public health budgets spent on mental health.

As well as the moral case, the economic case for public mental health interventions is overwhelming. In 2010, DH commissioned Professor Martin Knapp and his colleagues at the London School of Economics to undertake an analysis of the cost and economic pay-offs of a range of measures in mental health promotion, prevention and early intervention. The final report concluded that many of these approaches are "outstandingly good value for money".

The largest savings were found in prevention. They found that for every £1 invested in social and emotional learning programmes aimed at preventing conduct disorder in young people, the estimated return on investment to the NHS, other public bodies and the wider economy was £84.

Workplace health promotion programmes also saw a £10 return for every £1 spent, reinforcing the crucial role of employers in reducing the prevalence of mental illness.

Of course, there is a particular challenge when councils are feeling the pinch on public health budgets. In 2017/18, local authorities will receive £84 million less from central government for public health services, coming on the back of heavy cuts in previous years. When the NHS is under pressure, mental health loses out first. Mind's survey suggests that the same is true of public mental health spending. But it's the same short-sighted false economy, when the cost of mental illness is so vast and we know that prevention pays for itself.

For the last year, one of my major projects has been chairing the West Midlands Commission on Mental Health. Set up by the West Midlands Combined Authority, our remit is to examine the impact of mental ill health across the entire region, and explore how we can make better use of public funds to achieve improved outcomes and boost the economy.

Shifting resources from treatment to prevention is at the heart of our action plan, which focuses on the vital role of employers, housing, and the criminal justice system in tackling mental ill health.

How can public sector and non-public sector bodies work more effectively to promote mental health and wellbeing?

We came across inspiring examples of international best practice. In the United States, there are major public mental health programmes taking place across entire city-regions. New York, for example, has pioneered an impressive strategy called 'Thrive NYC'. It contains a number of high-profile commitments to improving mental health and preventing illness, mobilising people across different sectors including health, education, business, and the police. Philadelphia has also adopted a public health approach to mental health at population level.

The UK could learn a lot from these approaches. Under the banner of the International Initiative for Mental Health Leadership (IIMHL), there is an emerging global network of cities which are pursuing city-wide mental health initiatives. My ambition is for the West Midlands to be part of that elite.

Local authorities will be key players in the mission to achieve equality for mental health. If we invest more in public mental health, local communities will reap the benefits. Given the close link between mental and physical health, pressure on other public health services (such as stop-smoking services) will also be reduced. We certainly cannot continue to spend as little as we do now.

Norman Lamb was first elected as the Liberal Democrat MP for North Norfolk in 2001 and is the Liberal Democrat Shadow Secretary of State for Health and Social Care. He has previously been a minister at the Department of Health and was also a Norwich City Councillor.

Case study: Public health good practice from the Liberal Democrat led Bedford Borough Council

Tackling excess weight

Bedford Borough Council has worked with local health services to develop an excess weight partnership strategy to address the complex causes of obesity:

- Innovation funding from public health has enabled local provider BeeZee Bodies to develop 'Gutless', a weight management programme especially for men. The response to Gutless has surpassed expectations, and the programme is making a real difference to participants' lives.
- The Sports Development team are working with an organisation called Oomph! to deliver training and support to local care home staff to create exercise leaders who can provide inspiring and imaginative physical activity classes for care home residents. Regular activity for older people improves mobility, reduces frailty and falls, and improves mental wellbeing.

School nursing service drop-in sessions

One achievement since school nursing became a public health responsibility is the creation of weekly drop-in sessions for pupils in Year 7 and above. The school nurses are skilled to support pupils with a wide range of physical, social and emotional issues and more intensive help can be provided if necessary, and the feedback from pupils, schools and families has been positive.

AspireNLP

Improving self-esteem and emotional resilience is key to ensuring children and young people are able to achieve their aspirations and have healthy relationships. The AspireNLP programme motivates children 'at risk' to achieve their potential by focusing on the way they think and by improving their health and wellbeing.

Bedford Borough Council has provided AspireNLP programmes to schools in teenage pregnancy 'hotspot' wards, and this year for the first time, AspireNLP will run in the Pupil Referral Unit. AspireNLP has likely contributed to falling teenage pregnancy rates and there are measurable and sustained improvements in school attendance, self-esteem, aspiration and other outcomes.

Councillor Tim Brett

PUBLIC HEALTH IN SCOTLAND

Arrangements for the delivery of public health in Scotland are different from those south of the border. Health has been a devolved matter since the setting up of the Scottish Parliament, but different arrangements have existed for some time.

Public health is formally part of the role of each of the 14 territorial health boards in Scotland and each service is led by a director of public health (normally a consultant in public health medicine), but staff are made up from multi-professional backgrounds.

The Department of Public Health liaise closely with their colleagues in local government, but this can be difficult, as in many parts of Scotland, boundaries between the health board and the local authority are not always co-terminous.

One of the key issues in nearly every part of Scotland are significant variations in health outcomes between different communities, so that health inequalities are a key issue. This of course is linked to other areas, such as income levels, employment, housing, etc. As a result, many community planning partnerships will have inequalities as one of their key areas to be addressed.

Public health in Scotland can however, tell a good story, as it led the way in the United Kingdom on banning smoking in public places and deaths from heart disease and stroke have fallen significantly over the last 30 years.

But it is still the case that significant issues remain and require ongoing attention. Inequalities are the foremost of these, as has already been mentioned, but life expectancy in Scotland lags behind that of many other European countries and the big issues today are inactivity, diet and obesity, and poor mental wellbeing.

There is not a statutory committee responsible for public health, but in Fife we have the Fife Health and Wellbeing Alliance, which is made up of elected members and officers from both the NHS and the local authority and also includes representatives from the third sector, which works to improve long-term health and wellbeing outcomes.

Previously, additional funding was provided by the Scottish Government for this purpose. This has gradually been reduced over the last five years, but has meant that there can be local focus on particular areas.

The Scottish Government published a review in 2015 – A Review of Public Health in Scotland.

This has made a number of recommendations:

1. That further work should be undertaken to review and rationalise organisational arrangements for public health.
2. There should be the development of a national public health strategy and clear priorities.
3. There should be clarification and strengthening of the role of the directors of public health, both individually and collectively.
4. There should be more support and coherent action, and a stronger public health voice in Scotland (there is a Minister for Public Health within the Scottish Government).
5. There should be greater coordination of academic public health, prioritising the application of evidence to policy and practice and responding to technological developments.
6. There should be an enhanced role for public health specialists within community planning partnerships (CPP) and the new Integrated Joint Boards (IJBs).
7. There should be planned development of the public health workforce and a structured approach to utilising the wider workforce.

Most of the public health workforce is employed in one of the 14 territorial health boards, or in one of the national bodies which has responsibility for aspects of public health. There are currently four national bodies which have responsibilities in this area and a recommendation is that these should be brought together in a single, national organisation.

Scotland is also leading the way in the integration of health and social care with effect from April 2016. All 32 local authorities were required to set up integrated health and social care partnerships, or IJBs.

This will be a significant challenge, but unlike England, where pilots have been undertaken, the Scottish Government decided to move all health and social care into new organisations.

It is early days yet, to know what the benefits of this will be, but it is already apparent that new models of care are required if we are going to shift the balance of care from hospital to the community. The same problems, however, affect Scotland as other parts of the UK, particularly numbers of individuals who are trapped as 'delayed discharges'.

Many of the themes in public health are common to other parts of the UK :

a) The importance of both a national and local perspective and the need for coordination between these. The Scottish Government has a track record of centralising other services such as the police and fire services and it is clear that they intend to look at creating national public health arrangements, where they feel this would be appropriate.

b) There is a need for greater visibility and clear identity for the public health function and that there is always a risk that this is lost among wider concerns about acute care and delivery of services.

c) There is a desire for strengthened leadership from individuals and organisations in this important area.

d) There is recognition of the fundamental importance of effective partnership working as a prerequisite for better processes and also, finally, recognition of the changing nature of the workforce and the challenges of supporting and strengthening multi-disciplinary public health.

Scotland is a relatively small country with a population of just over five million, but covering quite large geographical areas.

While the UK should value the different approaches that are being taken, it is also important that we should continue to learn from each other as to what works in certain parts of the country and also where we can learn from others.

Local elected members often find it difficult to engage with the health agenda as there will normally only be one elected member on NHS territorial boards, but the new health and social care partnership arrangements have provided an opportunity for more elected members to be involved.

In Fife, for instance, we now have eight elected members on the new Integrated Joint Board. There are undoubtedly significant challenges as we move forward and Scotland will need to build on the successes it has achieved in the past to make sure that today's public health agenda is properly addressed.

Tim Brett was first elected to Fife Council in 2003. He is currently Leader of the Liberal Democrat Group. He was a senior NHS manager in Tayside and latterly was Director of Health Protection Scotland. Tim was Prospective Parliamentary Candidate for North East Fife in the 2015 General Election.

Councillor Chris White

EDUCATING PEOPLE ABOUT HEALTH

One of the signal achievements of the Coalition Government was to transfer the funding and responsibilities of public health to local authorities. One of the failures of the Conservative Government has been to cut those funds, even though in the long term this might well lead to higher costs.

Why the higher costs? The cheapest form of health service is one which does not get used. There can, of course, never be a situation in which every hospital bed is empty. We are all vulnerable to random injury, while childbirth is still something which often requires hospital rather than home care (there is a debate to be had here but this is not the place).

We all grow old and thus more vulnerable to late-life conditions that don't affect younger people. And there are many versions of ill health which are simply unavoidable, owing to genetics or conditions not yet fully understood.

But there is a large intermediate class of avoidable conditions – which are material in the number of people currently affected and the costs entailed.

One estimate indicates, for instance, that type 2 diabetes costs the NHS £1.5 million an hour. This is avoidable and preventable. But the focus of the NHS has long been about treating the disease and more particularly the consequences, which can be extreme.

When I recently quizzed doctors about this, I was told that there were indeed preventative measures in place: when a patient presents him or herself to a GP with the symptoms of type 2 diabetes, measures will be taken to prevent the condition worsening and so engendering potentially devastating long-term consequences.

This is good news but misses the point about healthcare and how we actually prevent conditions and save money.

Liberals value education highly. It is our answer to the nanny state; we give people the means to make informed choices and then let them get on with their lives. We prefer not to ban things like alcohol or cigarettes but rather educate people about the dangers.

For instance, educating teenagers about the prospects of unwanted pregnancies and how to avoid them is a key strand of the public health service. The alternative – preventing contact between teenagers – seems unrealistic and in any case illiberal. This is the 21st century and not the 19th.

The same must apply to type 2 diabetes. It is far too late to start educating people about healthy eating and healthy lifestyles when they turn up as an overweight, middle-aged man in a doctor's surgery.

The effort has to start rather earlier. And by this I mean much earlier.

Unhealthy eating starts in the home and at primary school. It is too easy to wink at a child's enthusiasm for chips with everything because at least 's/he has a healthy appetite.'

New parents need to be shown why a healthy diet from the word go is essential for their baby's whole life chances. They also need to be shown how to achieve that: no ban on chips, but a variety of meals which introduce vegetables at main meal times.

It is a tough ask for civic society. We not only have to educate children about healthy eating but also their parents.

Alcohol is no easier to tackle. My grandmother kept a bottle of sherry in the sideboard. It was there year in, year out and occasionally opened. Two generations on, most 20 year olds will recall episodes of being drunk beyond capacity and some seek this out every weekend.

Reaching younger people is difficult and suggestions such as raising the price of alcohol in supermarkets may have their place. Again, starting at school – in a way which does not sound nannyish and anti-fun – is key but probably not enough.

Some universities have a very strong pro-alcohol culture, often associated with freshers' week, and this gives a clue: working with students will be essential to any education drive.

All of this misses out the middle-class, often middle-aged topers: a bottle of wine with every evening meal and the 'oh what a ghastly day at work' gin and tonics are a risk to long-term health. This in turn challenges the effectiveness of the NHS in dealing with the consequences, which are not just plain alcohol dependency but include diabetes and other conditions exacerbated by unsafe levels of alcohol consumption. Somehow we have to reach out to this group as well.

But how effective is education likely to be? Certainly, education of the wrong sort – hectoring messages to younger people, for instance – is not going to work. Nor is education through the wrong medium.

In my area, the hard to reach groups, when it comes to political campaigning, are young people and those who are commuting in and out of London – and are basically out working or enjoying themselves. These are the same groups who need to be reached by the public health service and this means using social media (effective up to a rather limited point) as well as direct mail.

Doctors may need to write to people warning them of the need for a better lifestyle. When did you last get a letter from your doctor?

But will we ever be able to rely solely on education?

The classic case is cigarettes. There are probably now no people who regard cigarettes as good for you or even relatively harmless. Work in schools and the messages on packages are some of the reasons for this. But people still smoke – and worse people are still starting to smoke in the full knowledge of the risks.

Legislation has essentially banned smoking indoors. The smoking ban was an interesting challenge to liberalism, but most are satisfied that the harm principle is real: other people are harmed so it is reasonable to ban it. Moreover, most smokers probably regard the bans as a useful support for their efforts to give up (many smokers don't smoke indoors at home nowadays).

Even if education is not a sufficient remedy it is nevertheless a necessary part of the health package: I doubt, for example, there will ever be public consensus for a comprehensive ban on alcohol or on sugary drinks.

Effective education, reaching out meaningfully to those who need to hear the messages, will cost money. But the cost of not spending money on a real communications effort will be sufficient to bring down the NHS as we know it. So let's start now.

Chris White was first elected to Hertfordshire County Council in 1993, and since 2008 has served on St Albans City and District Council where he is currently Leader of the Liberal Democrat Group. He is currently Deputy Leader of the LGA Liberal Democrat Group.

Councillor Richard Kemp

SOMETIMES IT'S ABOUT REPEATING THE OBVIOUS

I am writing this just after talking to four BBC local radio stations about the fact that last year 41,000 young people went to their dental hospital for multiple tooth extractions. These are cases which are so bad that they cannot be dealt with in the dental surgery but need to be dealt with under general anaesthetic. In addition, of course there will be many other teeth extracted in the dental surgeries. This figure is appalling. And to add insult to injury it's getting worse. A 20 per cent increase in just two years. Imagine 16 year olds having dentures!

So what is the solution to this problem, I was asked. Was I able to talk about the powerful new drug or procedure that would cut this out? No. The solutions to this problem are exactly the same as they were more than a few years ago when I was little. Eat and drink less things with sugar in and brush your teeth properly night and morning. In fact one of the interviewers accused me of being part of the nanny state. Well I've never had a nanny – just a mum that cared – but I am afraid that sometimes we do just need to repeat the obvious truth that parents must take more responsibility for what they allow their children to eat and drink.

I was also asked if I practised what I preached. I was able to say that my children have had very, very few fillings and they are all in their mid-30s.

I can also say that my grandchildren drink very little sugary stuff and that when they come to stay at our house almost the first thing they think of to bring is their toothbrush.

This is true of so many of the things that we need to talk about in our public health role. Obesity is rising (or should I say spreading) at an alarming rate. No big solutions just eat less; eat more responsibly and exercise more.

Too many elderly people have too many trips and falls. The biggest solution to this is to remove mats and other things which create unnecessary obstacles in their own homes.

Too many young people (and increasingly newly retired people) suffer from sexually transmitted diseases. Yet again the solution are obvious – practice safe sex.

Dealing with these problems which are largely avoidable is a major way of ensuring that the NHS has the cash to deal with the problems of illness which are not so easily avoidable. Obesity costs us £51 billion every year. The tooth extractions described above cost us £36 million a year. We know from countless studies that for every £1 spent on public health work £15 is saved somewhere in the health service.

If over a period of, say, five years we could make a major input into preventable health issues the cash, and in many cases the beds, would be freed up with marginal increases to the overall level of NHS spend.

Within our communities we need to act in three ways:

- There are times when we must be absolutely blunt in telling people that they are themselves a major cause of their own ill health. The prime responsibility for good health lies with the individual or in the case of children their parents.
- We must make more information available to individuals and parents about the bewildering number of options open to them. For example most people think that high fibre cereals are healthy. In part that is true but only if you discount the extremely high levels of salt and sugar in them.
- We need to make healthy ways of living, eating and drinking fun. Waving the finger or the big stick has only a limited effect and can often be counterproductive. Far better, for example, to raise the idea of healthy food in cookery clubs where you bring people together for a social purpose and show them good tasty food is easy to cook and cheap.

So much of what we need to say can be done in ways that are appealing and fun. People love talking about food (and eating it). 'Walk a mile' events and 'park runs' can be a bit of an ordeal if you are out of condition but after the first three or four sessions become easy, fun and companionable.

Crucially, in my view, these are not things that should just be left to the council or the public health department. It should be a responsibility for every councillor to raise public health issues on their patch. Talk to your schools, park managers, youth clubs and churches about what they can do. Ask them what they know about the health situation of the people they look after. See how a local community based and community led partnership can do things together.

Look at some of the schemes operated by national charities and ask them to work with you on neighbourhood activity. As an example the Alzheimer's Society is very keen to establish Dementia Friendly Neighbourhoods where there is a community wide understanding of dementia and the appropriate responses that can be taken to minimise the problems to those have the condition.

It may be stating the obvious to say that we must continually state the obvious. However the simple basic ways of ensuring healthy lives are too often overlooked in the busy, busy, busy lives that we have. Our job in a friendly but persistent way is to remind people of what they know to be true and help them put that knowledge into practice in their everyday lives.

Richard Kemp has served as a Liberal then Liberal Democrat Councillor between 1975 and 1984 and from 1992 to date. He has previously been Leader of the Liberal Democrat Group at the Local Government Association and is currently the LGA Liberal Democrat Group's spokesperson on Social Care and Health, is Deputy Chair of the LGA Community Wellbeing Board, and sits on the Liberal Democrat Federal Policy Committee.

OUR ASKS OF CENTRAL GOVERNMENT FOR PUBLIC HEALTH

1. Introduce effective legislation to ensure that all foods are labelled with salt and sugar levels per portion for adults and children.
2. Restore the cuts in grants to local government for public health purposes. Remember every £1 spent of illness prevention saves £15 on illness cures.
3. Introduce powers to allow councils to prevent fast food outlets and their advertising to open within 500m of a school.
4. Introduce legislation which provides a legally binding watershed on adverts for products with high sugar and salt contents to reduce the pester power of children.
5. A minimum pricing policy for alcohol.
6. Spend the money to be raised from the 'Sugar Tax' through local government so that the maximum impact can be made in the areas of greatest need.
7. Implement the recommendations contained within the '1,001 critical days' cross party report to ensure all babies have the best possible start in life.
8. Follow the example of Scotland in providing each newborn baby with a selection of appropriate 'goodies' to enable their parents to establish healthy and safe habits for their children from day one.
9. Give councils greater powers to take action to ensure the reduction of emissions when safe emissions levels are in excess of recognised standards.

OUR ASKS OF LOCAL GOVERNMENT FOR PUBLIC HEALTH

1. Recognise that everything a council does leads to good or bad health outcomes. Adopt an 'all council' approach to public health which recognises that all departments can play a part. Adopt a 'Health in All Polices' approach.
2. The prevention of mental ill health should be central to all-council public health strategies. Each strategy should contain clear measures to promote good mental health and prevent mental health problems from arising, along with a commitment to a year-on-year increase in the proportion of public health budgets spent on mental health.
3. Ensure that the director of public health is a full player in all key officer activities and is invited to comment and support a range of activities throughout the council.
4. Make sure all departments understand the public health directions of the council. Having an effective obesity and oral hygiene strategy will never be adequately supported if your PR department plugs the Coca-Cola van visit and other similar events. Each local authority to circulate brochures outlining 'all council' approach to public health, to all staff in all departments, with annual training sessions.
5. Make sure that all councillors have access to details of the health and demography of their wards and encourage them to develop local partnerships and take local actions in support of council wide strategies.

6. Remember that the CCG and NHS trusts are not the only service providers. Front line services such as opticians, dentists, GPs and pharmacists can and should play a major role in pushing key public health messages.
7. Local authorities should actively promote public awareness of local pharmacies and the services they can provide, eg by working with local newspapers/billboards etc.
8. Set the lead by examining what food and drinks are sold in your health centres, in vending machines on your premises and provided in care establishments under your control to clearly be providing good, healthy food.
9. See schools as a key partner. It's not just the meals they serve but also the lessons they have on public health issues and the encouragement that they can give to youngsters and their parents about healthy exercise. Programmes such as Walk a Mile a Day programmes cost little and can be great fun with quick health and fitness outcomes.
10. Introduce policies to encourage active travel and use of public transport to improve the quality of local environments and improve road safety, health and wellbeing.
11. Provide a 25 per cent increase in cycle lanes and cycle racks by 2025 using 2017 as a base.

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